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## Surgery

### The Surgery of Congenital Heart Disease\*

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In 1939 Gross and Hubbard<sup>1</sup> reported the first successful closure of a persistently patent ductus arteriosus. By this pioneering operation Gross opened the door to the development of cardiac surgery, so that now—within the space of only a few years, many patients otherwise doomed to die of their heart conditions, can be salvaged by surgery and can be allowed to lead normal lives.

This paper is concerned with the diagnosis and treatment of a few of the congenital heart lesions for which surgery is now well established.

#### Patent Ductus Arteriosus

The ductus arteriosus is a normal fetal pathway extending from the bifurcation of the pulmonary artery to the aorta just distal to the origin of the left subclavian artery. During intrauterine life the blood is shunted away from the non-functioning lungs through the ductus into the systemic circulation. At birth, the lungs expand and the pulmonary vascular pressure is reduced to a level the same as the aortic pressure, so that little or no blood flows through the ductus. In the normal infant the ductus then undergoes obliteration and this process is usually complete by two months of age. If the ductus should fail to become obliterated then there is a gradual increase in the aortic pressure over that in the pulmonary artery, and the blood is shunted from the aorta into the pulmonary artery—just the opposite of its flow during fetal life. This shunt may be large, consisting of from 20 to 70% of all blood pumped by the left ventricle. Since this shunt takes several months or years to develop, the typical murmur is not usually heard until about two years of life. If this development of the murmur is not explained to the parents of the child, many of them lose confidence in their pediatrician because he did not discover the condition during infancy.

The cause for the failure of the ductus to close is not known. There is some indirect evidence, however, that German measles sustained by the mother during the third month of pregnancy may in some way affect the fetus so that the ductus fails to close after birth. Research workers have noted that a large proportion of patients with a persistently patent ductus are born during the summer months and that their third month of

intrauterine life corresponds very closely with the peak incidence of German measles in their communities. Not included in this group are patients with the syndrome of patent ductus, cataracts and cleft palate, for which there is considerable direct evidence that German measles is the etiological factor.

#### Symptoms

Children usually have few or no symptoms as a result of their patent ductus. They are not cyanotic, their exercise tolerance is usually normal, but in some instances their growth is somewhat retarded. As they grow older, however, they frequently suffer from abnormal fatigue and find that they have to limit their activity. Approximately two-thirds of the patients with a patent ductus get into serious difficulty before their fortieth birthday, either because of failure of the heart, or because of the development of bacterial endocarditis.

#### Diagnosis

Patients with a persistent patency of their ductus develop a highly characteristic murmur. This murmur is best heard in the second rib interspace along the left border of the sternum. The murmur is continuous and is "machinery-like" in character. It is usually quite loud and is transmitted to the vessels of the neck. A thrill, similar to the murmur is present.

The heart is usually slightly enlarged, the pulse pressure is typically wide, with a low diastolic pressure. A "Corrigan" type of bounding pulse may be present, and capillary arterial pulsation may be visible in the nail beds.

By X-ray the heart is seen to be slightly enlarged with a prominence in the region of the pulmonary artery. The pulmonary vascular markings are increased as a result of the increased flow of blood through the lungs, and in large shunts the pulmonary hilar vessels may be seen to pulsate, giving the so called "hilar dance."

Because of the increased load upon the left ventricle, the EKG is normal or shows left ventricular predominance.

In the typical case, with the above findings, there is no need for further investigation as the diagnosis of patent ductus is almost certainly correct.

If the shunt is very large, however, with the large volume of blood in the pulmonary system, the pulmonary artery pressure may increase to a point equal to the aortic diastolic pressure. When this occurs, there is no longer a flow from aorta

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to pulmonary artery during diastole, and only a systolic murmur is heard. In such instances, while one can suspect the presence of the ductus, the diagnosis cannot be established on the basis of the murmur so that it is necessary to perform further investigation. The patency of the ductus is best demonstrated by doing an aortogram. This is done by injecting radio-opaque dye into the aorta in a retrograde manner through the left carotid artery. It is necessary to "cut down" on the artery. During the rapid injection both carotid arteries should be compressed so that the dye does not flow to the brain. By this means the actual ductus may be visualized on the X-ray film, or it may be established that a shunt is present by visualization of the dye in the pulmonary artery at the same time as it is present in the aorta.

#### Treatment

Because of the frequency of serious difficulties later in life, and because the operative mortality for division of the patent ductus in uncomplicated cases is under 0.5%, I believe that all patients with a persistent patency of the ductus should have surgical closure performed. The operation is best performed during childhood at from six to ten years of age, as at this age the dissection is easy and the children make quick and uneventful recoveries.

Intratracheal ether anaesthesia is used. The surgical approach is through the left anterior chest in the third interspace. The lung is retracted out of the way and the pleura is incised just posterior to the phrenic nerve in the region of the pulmonary artery. The vagus nerve and its branch—the left recurrent laryngeal nerve which goes around the ductus, are identified and carefully preserved. The ductus is then dissected clean so that it is completely exposed on all sides. It is then possible to place four hemostatic clamps across the ductus and divide the ductus between the two middle clamps. The distal clamps on both ends of the divided ductus are then removed and the cuff of each end is sewn over by a continuous inter-locking suture of 5-0 arterial silk. The proximal clamps are then removed and the pleura is closed. The chest wound is closed without drainage, although during closure a catheter connected to suction is left in the wound in order to evacuate all air and blood remaining in the pleural space. Following the operation, the children are usually up and out of bed on the second or third post-operative day. Their sutures are removed on the seventh day and they are usually home before the tenth post-operative day. All patients are given prophylactic antibiotic therapy for a few days following their operation. With this technique of dividing the ductus there have been no recurrences of the shunt as there

occasionally were, when the ductus was simply ligated in continuity.

#### Coarctation of the Aorta

Coarctation of the aorta is a congenital condition in which there is an acute narrowing or complete obstruction of the aorta just distal to the origin of the left subclavian artery, at or near the site of the ligamentum arteriosum. The circulation to the body below the coarctation is maintained through various collateral anastomoses, which are principally through the internal mammary and the intercostal arteries. The cause of the condition is not known.

#### Symptoms

Most children born with a coarctation of the aorta have few or no symptoms, although an occasional infant with coarctation will have a difficult time during the first few months of life with evidence of heart failure. If these infants are given supportive therapy, including oxygen and digitalis, they can usually be tided over without surgery until their collateral circulation develops and relieves the strain upon their heart. In later life, usually around thirty years of age, the patient with coarctation may develop frequent headaches, nosebleeds, and pains in the legs. Their spouses may complain of their bed-mates' continual cold feet. In a high percentage of cases, the continued aortic obstruction and the resulting upper-body hypertension leads to the death of the patient either through failure of the heart, through rupture of an intra-cranial artery or through the development of subacute bacterial endocarditis. A few patients develop a post-coarctation aneurysm which may go on to rupture.

#### Diagnosis

Once the condition is suspected it is extremely easy to make the diagnosis in a typical case of coarctation of the aorta. The patient has high blood pressure in the arms, with low or no blood pressure obtainable in the legs. The femoral pulses are generally absent or greatly diminished. The patient is not cyanotic. There is usually a marked arterial pulsation at the base of the neck, and typically the patient is a broad-shouldered, thin-waisted individual. The heart may be slightly enlarged and there may or may not be a systolic murmur present overlying the region of the coarctation. Frequently a hum and a thrill can be elicited over the chest due to the tremendous load of blood that is being carried through the collateral intercostal vessels.

Chest X-ray reveals notching of the under-surface of the ribs, and it is not infrequent for the diagnosis of coarctation to be first made by the radiologist on reading a routine chest film.

At fluoroscopy, the aortic knob may be diminished and the barium filled esophagus may be

indented by the aorta in a characteristic manner, giving the so-called "E" sign.

The electrocardiogram shows left ventricular hypertrophy.

In the typical case no further investigation needs to be carried out. Occasionally when the findings are atypical it is necessary, either by angiography or by an aortogram, actually to visualize the area of coarctation.

#### Treatment

The first successful excisions of coarctation of the aorta were almost simultaneously performed by Crafoord<sup>2</sup> in Sweden and Gross<sup>3</sup> in Boston in 1945. The optimal age at which surgery should be performed is around ten years but because the diagnosis is not frequently made until a later age, the majority of patients are operated upon in their twenties. If possible it is advisable to delay surgery prior to the age of nine or ten years, since the growth of an aortic anastomosis in an infant or small child may not keep apace with the growth of the child. Thus later in adult life, a relative narrowing of the aorta might still exist.

The operation is performed through the left chest which is entered in the fourth interspace. It is necessary to obtain a wide exposure so that the incision is a long one. The aorta above and below the area of the coarctation, along with the left subclavian artery and the adjacent intercostal and bronchial arteries must be completely dissected free. The ligamentum arteriosum is divided. It is then possible to place clamps across the aorta above and below the coarctation. These aortic occluding clamps do not deprive the lower body of any significant amount of blood since the patient's aorta was previously obstructed by the coarctation, and his circulation is through the collateral channels. The area of coarctation can then be excised and the divided ends of the aorta are anastomosed with interrupted evertting mattress sutures of 5-0 silk.

The aortic clamps are then slowly removed to allow an unobstructed flow of blood down through the aorta.

Following the operation the patient's upper extremity hypertension disappears, femoral pulses become palpable, and the blood pressure in the legs becomes (as it should be in the normal), slightly higher than that obtained in the arms.

Instead of being an acute narrowing, in some instances the coarctation is long, or there is an aneurysm present, so that a direct anastomosis is impossible. To bridge the defect in these cases, it is necessary to employ an aortic graft. This graft is a segment of aorta obtained from a young individual under sterile conditions shortly after death. The aorta can be stored, ready for use in a frozen state or in a tissue culture medium. When inserted into the host, these grafts do not live

but simply act as a scaffold for the growth of new endothelial elements. Over forty aortic grafts have been employed in the Boston Children's Hospital and although the follow-up is short (only five years for the longest) the results have been extremely gratifying.

#### Vascular Compression of the Trachea or the Esophagus

Certain developmental abnormalities of the aortic arch and the great vessels may occur in such a way that a constricting ring surrounds the trachea and esophagus; or these structures may be individually compressed by abnormal positions of the great vessels. There are too many combinations of vascular anomalies capable of producing this syndrome to discuss all in any detail, so that only a few of the more commonly encountered lesions will be mentioned.

#### Symptoms

Infants born with vascular ring compression of trachea and esophagus have symptoms referable both to swallowing and to respiratory function. If the compression is exerted primarily on the esophagus the infants usually have considerable difficulty in getting their feeding down, particularly, when the infant is given solid foods. Due to the esophageal obstruction the feeding may overflow into the larynx, so that aspiration is a frequent complication.

If the trachea is also markedly compressed by the vascular abnormality, then the infant may have a continual stridor and typically will keep his neck hyperextended to improve his airway. Pneumonia is frequent and commonly is the cause of death.

#### Diagnosis

In most instances from a study of the X-ray films taken during barium swallow and lipiodal tracheogram, it is possible to determine the nature of the vascular abnormality.

#### Treatment

Radiologists often see minor indentations of the barium filled esophagus which are not productive of symptoms. When the symptoms are severe, however, surgical relief of the tracheal or esophageal obstruction is indicated as otherwise the infant will almost certainly die as a result of his repeated pulmonary infections.

No matter the type of lesion present, experience has shown that the best surgical approach is through the left anterior chest. In most cases it is necessary to resect most of the thymus gland and then by delicate dissection to expose completely the aortic arch and great vessels. The exact nature of the vascular abnormality can then be ascertained and measures taken to break the constricting ring.

### Aberrant Right Subclavian Artery

Probably the most common vascular abnormality is an aberrant right subclavian artery which causes obstruction to the esophagus alone. The symptoms, however, are frequently respiratory in nature because of aspiration. In this situation the right subclavian artery, instead of arising from the innominate artery, has its origin from the descending aorta on the left side of the chest. The artery then courses upwards and to the right behind the esophagus to supply the right arm. By X-ray the barium filled esophagus has a posterior filling defect which runs obliquely up from left to right.

Surgical correction of the esophageal obstruction in this instance can easily be accomplished by dividing the aberrant right subclavian artery between ligatures close to its origin from the aorta. The divided artery is then allowed to retract from behind the esophagus, over to the right side, thus relieving the obstruction. The blood supply to the right arm is adequately maintained through collateral vessels.

### Double Aortic Arch

A true vascular ring is produced when a double aortic arch surrounds the trachea and esophagus. Relief of the tracheal and esophageal obstruction is accomplished by surgical division of the smaller arch. Even if this arch lies posteriorly, its division can be accomplished without great difficulty by a surgical approach through the left chest.

### Right Aortic Arch With a Persistent

#### Ligamentum Arteriosum

When the aorta descends on the right side of the body then the ligamentum arteriosum may produce a vascular ring as it courses from the pulmonary artery in front of the trachea, around to the left of the trachea and esophagus to join the right sided aorta posteriorly. The obstruction can be overcome by dividing the ligamentum.

For the first two or three post-operative days the infants are kept in a croup tent to minimize tracheal mucosal irritation and edema. A few days following the operation, the child's symptoms of stridor and difficulty in swallowing are completely relieved.

### Tetralogy of Fallot

This is the most frequently encountered condition present in children with cyanotic heart disease. The first classic description of the pathological anatomy of this abnormality was made by Fallot in 1888. The condition, however, remained a pathological curiosity until 1945 when Taussig suggested to Blalock at Johns Hopkins Hospital that something could be done for these poor unfortunate "blue babies" if some method of increasing the blood flow to the lungs could be accomplished. Blalock<sup>4</sup> working first in the dog lab and then later on patients found that he

could markedly improve these children by transplanting either the left subclavian artery or the innominate artery into a pulmonary artery thus increasing the volume of blood flowing through the lungs. The operation helps these children to a marked degree but is by no means curative. A further compensatory defect has simply been added to an already badly deformed heart. Subsequently in 1946 Potts<sup>5</sup> of Chicago and his co-workers introduced a technical variation of the operation whereby blood is shunted directly from the aorta into the pulmonary artery. More recently, Brock<sup>6</sup> in London and Glover, Bailey, and O'Neill<sup>7</sup> in Philadelphia have made a direct attack on one portion of the tetralogy by relieving the pulmonic stenosis. It is still too soon to tell whether this more direct approach will prove superior in the long run to the indirect approach of Blalock and Potts.

There are four defects in a heart with tetralogy of Fallot. These are pulmonic stenosis which may be valvular or infundibular in type; an interventricular septal defect; an over-riding aorta; and right ventricular hypertrophy. With this combination of defects, venous blood in the right ventricle finds it difficult to enter the pulmonary artery because of the stenosis, and therefore, flows through the interventricular septal defect to mix with arterial blood in the left ventricle and to be distributed to the body through the over-riding aorta.

### Symptoms

These children are all blue. The degree of cyanosis and of limitation of activity varies greatly and depends upon the amount of venous blood being shunted through the interventricular septal defect into the aorta. The cyanosis may be noted immediately after birth but is usually slight and becomes more marked only after closure of the infant's ductus arteriosus. In the severe case the child is extremely blue almost to the point of being black and quickly gets into serious difficulties. Convulsions are common and often lead to the death of the child. In the less severe case, the child may grow up with slight to moderate cyanosis and with moderate to marked limitation of activity. These children characteristically squat at frequent intervals while playing.

### Diagnosis

The cyanosis is most apparent in the mucous membranes and in the nail beds. The fingers and toes are clubbed. The children are frequently small for their age and their development is usually retarded. Their heart size is normal. On auscultation a systolic murmur is heard over the entire precordium with its greatest intensity in the pulmonary region. The second pulmonic sound is diminished or is absent.

By X-ray the heart is boot shaped and the pulmonary vascular markings are markedly dimin-

ished. The electrocardiogram shows right ventricular hypertrophy. In the typical case no further investigation is required but when the findings are atypical angiography and cardiac catheterization maybe of great help.

#### Treatment

In an effort to increase the oxygen carrying capacity of the blood, these children all have hemoconcentration and their hematocrit levels may be as high as 80 or 90%. It is extremely important that these children be given as much fluid by mouth as is possible, because if they should become dehydrated, then the resulting excessive hemoconcentration may lead to spontaneous thrombosis, particularly in the cerebral vessels.

When one is forced to operate early in life because of the severe nature of the disease, the mortality rate is very high, amounting to 25 or 30%. This high mortality is accounted for not only because of the poor risk patient but because of the difficulty of working with small vessels and their tendency to thrombose at the site of the shunt after its establishment.

Beyond three years of age the mortality is between 5 and 10%. Therefore, whenever possible it is preferable to avoid operation in the first two or three years of life and to defer it until an older age when the risks of surgery are less and the promises of a satisfactory result are brighter. In general, the surgical approach is through the left chest. The best results are obtained when a Potts side-to-side pulmonary-aortic anastomosis is established. In about 20% of cases, however, the aorta is right sided and then it is necessary to perform the Blalock-Taussig subclavian-pulmonary artery anastomosis.

Following operation these children are immediately improved and their cyanosis markedly diminished. Even by the tenth or twelfth post-operative day, when the child goes home, it is noted that his exercise tolerance is markedly increased.

#### Tricuspid Atresia

Tricuspid atresia is a less common cause of cyanosis than is tetralogy of Fallot. In this condition the tricuspid valve is completely atretic or obstructed and the right ventricle is rudimentary. There also must be present interatrial and interventricular septal defect through which blood is shunted if these children are to live at all. The circulation of blood is as follows: venous blood is returned to the right auricle and is then shunted through the interauricular septal defect into the left auricle and from there into the left ventricle. Some of the blood then makes its way through the interventricular septal defect into a small right ventricle and then flows out through the small hypoplastic pulmonary artery to the lungs.

Because there is a complete mixing of venous and arterial blood in the left side of the heart these children are deeply cyanosed.

#### Diagnosis

The cyanosis is intense with clubbing of fingers and toes. A history of squatting may be present. The heart may or may not be enlarged. A systolic murmur is usually heard, but it is quite variable and is of little diagnostic aid.

By X-ray it is seen that the size of the right ventricle is greatly diminished; that the left ventricle is enlarged; and that the shadow normally cast by the pulmonary conus is diminished as is also the pulmonary vascular bed. By EKG there is left ventricular hypertrophy as opposed to the right ventricular hypertrophy present in tetralogy.

#### Treatment

Operative treatment of the condition by establishment of an aortic-pulmonary shunt has given beneficial results, but carries a much higher fatality rate than for tetralogy; furthermore cardiac failure subsequently occurs in a considerable number of cases after operation.

#### Pure Pulmonic Stenosis

In this situation a marked pulmonary artery stenosis exists without other cardiac abnormalities.

#### Symptoms

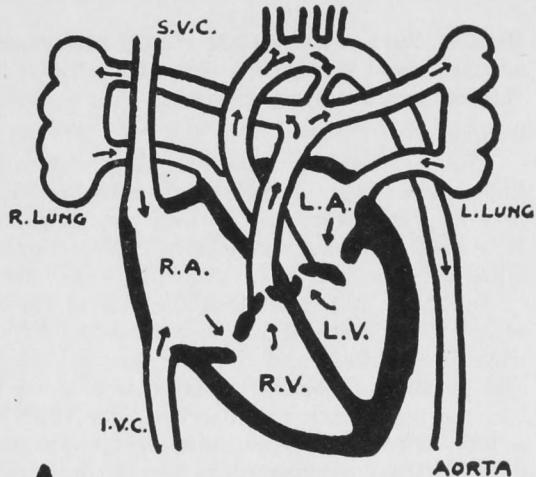
The patient usually shows little or no distress when at rest or at mild activity. With increasing exercise, however, the flow of blood through the circulation becomes held up at the area of the pulmonary narrowing and symptoms appear. These symptoms are mainly dyspnea, palpitation, and weakness. There is no true cyanosis since there is no mixing of venous and arterial blood. An extreme pallor may be present at times and there may be a faint duskeness of the lips and nail beds. Clubbing of the fingers is absent or minimal and squatting is unusual.

#### Diagnosis

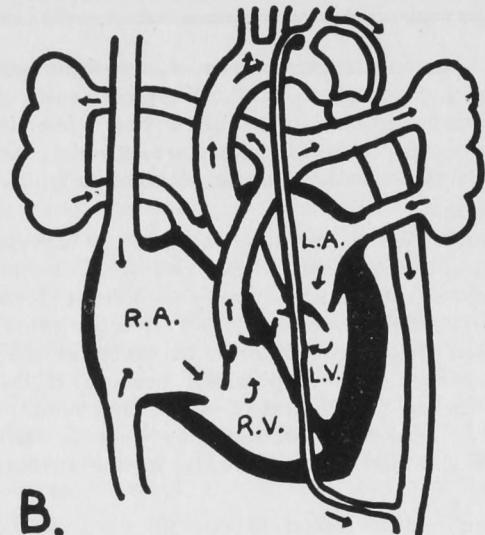
The outstanding finding on physical examination is a very loud blowing murmur, generally accompanied by a thrill, systolic in time, which is most intense in the second or third interspace to the left of the sternum. The second pulmonary sound is absent or is greatly diminished. The heart is frequently enlarged.

By X-ray and fluoroscopic study the right ventricular is always enlarged with diminished pulsation in the pulmonary artery and its branches. The pulmonary artery, however, may be markedly enlarged due to post-stenotic dilatation. This finding is a particularly fortunate one because it usually indicates that the stenosis is valvular rather than infundibular in type. The electrocardiogram shows marked right ventricular hypertrophy.

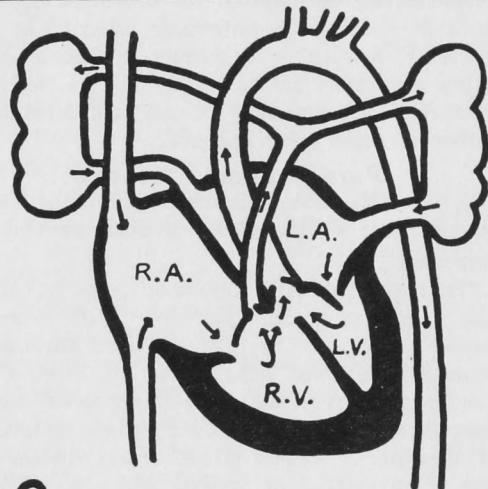
Visualization of the right side of the heart and the pulmonary artery by angiography is



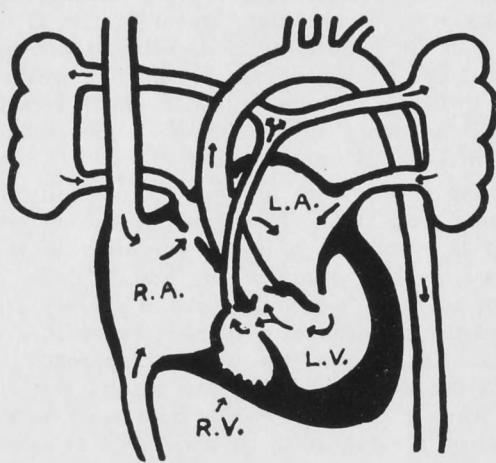
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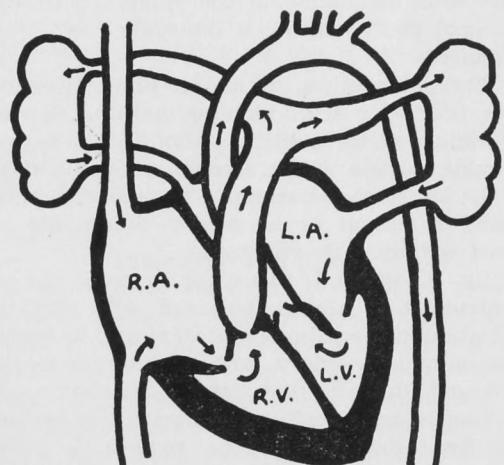
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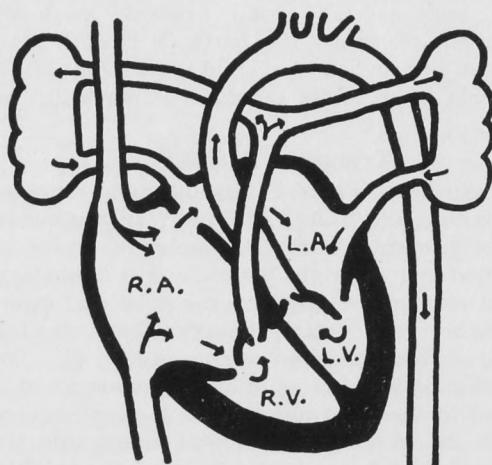
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not always necessary but is sometimes helpful, as in some instances the actual narrowing of the pulmonary outflow tract can be demonstrated. Cardiac catheterization is extremely helpful in ruling out the presence of other congenital heart defects and it is also often possible to determine whether the stenosis is at the valve or in the infundibulum.

#### Treatment

In the more favourable valvular type it is possible to overcome the obstruction by performing a pulmonary valvulotomy (Brock procedure). The surgical approach is through the left anterior chest. The pericardium is opened and a small incision is made into the right ventricle. It is then possible, without much bleeding, to introduce a valvulotome into the right ventricle and up through the pulmonary valve to slit it. Upon withdrawal of the valvulotome, the wound in the right ventricle is then sutured. The pericardial opening is partially closed and the chest wound approximated with under water catheter drainage in place. In the infundibular type of obstruction, the treatment is not nearly as satisfactory—an attempt is usually made to cut out or to dilate the area of constriction.

Improvement in the exercise tolerance of these children is not usually apparent for two or three weeks after surgery, when the effects of the operation itself have passed.

#### Pulmonic Stenosis Combined With Septal Defect

If in addition to the pulmonary stenosis there is also a septal defect either between the auricles or between the ventricles, then shunting of venous blood through the septal defect occurs, and the children are cyanotic. They can be improved by means of the Blalock or Potts procedure as is used in tetralogy of Fallot, but the best results are obtained if the pulmonary obstruction can be overcome by means of the Brock valvulotomy.

#### Summary

While there is still yet a great deal to be learned concerning the diagnosis and treatment of congenital heart disease it is now possible by surgery

to cure or to greatly relieve a good many children suffering from the crippling effects of their heart lesions. Surgical therapy is now well established for patent ductus arteriosus; coarctation of the aorta; vascular compression of trachea and esophagus; tetralogy of Fallot; tricuspid atresia; and pulmonic stenosis. The diagnosis and surgical treatment of these conditions are briefly discussed in this paper.

#### Captions for Illustrations

- A. Patent Ductus Arteriosus.
- B. Coarctation of the Aorta with collateral circulation through internal mammary and intercostal arteries.
- C. Tetralogy of Fallot showing pulmonic stenosis; interventricular septal defect; over-riding aorta; and right ventricular hypertrophy. The patient is cyanotic.
- D. Tricuspid Atresia. Circulation to the lungs is through the interatrial septal defect into the left heart, then through the interventricular defect into the small right ventricle; and then into the hypoplastic pulmonary artery. The patient is very cyanotic.
- E. Pure pulmonic stenosis, with post-stenotic dilatation of the pulmonary artery.
- F. Pulmonic stenosis with interatrial septal defect. The patient is cyanotic.

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## Anaesthesiology

### The Treatment of Barbiturate Poisoning

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It has been estimated that there are 1,500 deaths from Barbiturate poisoning each year in the U.S.A. Some, at least, of these deaths may have been prevented if a proper understanding of the pharmacology of Barbiturates and the resulting Pathology in the patient is understood.

#### Classification

Barbiturates are classified according to their clinical actions.

**Long acting**, e.g., Phenobarbital, Barbitol (Veronal). These are mainly eliminated by the kidney-80%, and partly detoxified by the liver-20%.

**Intermediate acting**, e.g., Ipral, Dial. These are partly eliminated by the kidney-20% and the balance is destroyed by the liver-80%.

**Short acting**, Amytal, Seconal, Nembutal and others. These are the commonly used drugs today and are almost entirely destroyed by the liver-100%.

**Ultra Short acting drugs**, e.g., Pentothal, Sural, Kemithal. These drugs diffuse rapidly into the tissues of the body and into the fat depots. This reduces the plasma concentration rapidly. From the fat depots the drug is slowly reabsorbed into the plasma in sub-hypnotic doses and is broken up mainly by the liver and also by enzymes in the blood at the rate of 7% to 15% per hour.

All these drugs are modifications of the Barbituric acid ring mainly in the "5" position.

#### Duration of Action

Barbiturates last from 6½ to 20 hours depending on their type, either short acting or long acting.

#### Physiologic Effects

Barbiturates are hypnotics but are poor analgesics. Varying degrees of cerebral depression can occur. The phenyl radical such as is present in Phenobarbital increases the toxicity of the Barbiturates.

Moderate depression with barbiturates will produce an apparently normal sleep. Larger doses depress the medullary centres.

#### Respiration

The rate and depth of respiration is decreased. This increases the CO<sub>2</sub> accumulation in the body tending to produce a gaseous acidosis. The oxygen exchange is reduced producing a form of Anoxic Anoxia.

Anoxia of the brain results in an intracellular oedema of the brain cells. If it persists, a mechanical obstruction to the circulating oxygen is set up,

and the oedema increases. Lucas suggests, that increasing the osmotic pressure of the blood, is the best means to combat the cerebral oedema. Seldon and associates of Rochester, Minnesota, have postulated that cerebral oedema might be the cause of Post Anaesthetic encephalopathy. Their treatment of this Cerebral Anoxia and Oedema is Human Serum Albumen, I.V., to remove the mechanical interference for the oxygen supply to the brain.

Barbiturates are para-sympathomimetic in character and may cause laryngo-spasm and broncho-spasm, thus increasing the anoxic episode.

#### Liver

Liver glycogen is depleted and the liver function is reduced as evidenced by dye tests. This may slow the destruction of short acting barbiturates by the liver.

#### Cardio Vascular System

Large doses of Barbiturates depress the Vaso motor centre, causing a fall of B.P., and thereby slowing the oxygen carriage of the blood. The Barbiturates also dilate the capillaries. This causes an increased permeability of the vessel wall. If it is associated with a mechanical inspiratory obstruction, such as a tongue obstructing the larynx, Pulmonary Oedema readily develops.

#### Kidney

Large doses of Barbiturates, as in general anaesthesia, causes an oliguria, probably through a central inhibition of the Hypothalamic-pituitary system. Any hypotension that results may further reduce the urinary output, and thus inhibit the elimination of Barbiturates via the kidney.

#### Treatment

1. An adequate nasal or oro-pharyngeal airway is vital. Oxygen through a nasal catheter helps to combat anoxia. If the patient develops pulmonary oedema, or does not show any signs of recovery in the first 24 hours, an immediate tracheotomy should be performed. If necessary, an endotracheal tube can be inserted through the larynx. Suction by a catheter can keep the airway clear, and oxygen can be directed to the tracheotomy opening.

It has been shown that poliomyelitis patients with any respiratory embarrassment do better with a tracheotomy. Secretions in the pulmonary tree are rapidly removed, and hypoxia and cyanosis are kept to a minimum. It was felt that the development of hypoxia could be more damaging than the poliomyelitis.

Mousel claims that slightly diminished oxygen can cause mental confusion and unconsciousness. A greater lack of oxygen can cause death in a comparatively short time.

Therefore, to repeat, the oxygen must be made available to the brain by keeping a clear tracheo-bronchial passage.

2. **Gastric Lavage**—to remove any drug that may be present.

3. **Analeptics.** These drugs are used in sub-convulsant doses which increase the need of the anoxic brain cells for oxygen. Picrotoxin has reduced the sleeping time in mice after pentothal anaesthesia, but does not increase the elimination of the drug. It is felt by many that analeptics should not routinely be used in barbiturate poisoning.

It is hereby recommended that analeptics should only be used when respiration is abnormal.

Picrotoxin is the drug of choice.

**Dosage:** One gram in one thousand ccs. of 5% dextrose in water. One cc. (one milligram of picrotoxin) per minute intravenously until the patient shows signs of respiration returning to normal. The maximum dose is 100 to 150 mgms.

**Metrazol**—one to 3 ccs. of 10% intravenously.

**Benzedrine**—10 to 40 mgms. in one per cent solution intravenously. Repeat at half hourly intervals.

4. **Vaso-pressor drugs** should not be given routinely. They constrict cerebral vessels and reduce the cerebral blood flow. If the blood pressure has fallen markedly, it may be given as an intravenous drip and the rate is regulated according to the blood pressure.

5. **Supportive therapy** consists of intra venous dextrose and fluid. A catheter should be left in the bladder. An increased urinary output eliminates some of the circulating drug.

6. **Hypertonic intravenous solution**—when the patient is unconscious for a longer period of time than the barbiturate should produce, one must assume that there is a cerebral oedema. Methods to increase the osmotic pressure of the blood and so decrease the cerebral cellular oedema should be considered.

Human serum albumen is the method of choice. It is expensive and is available in the U.S.A. It is used in a 25% solution. The rate is 50 ccs. per hour up to 300 ccs. A rapid infusion may cause convulsions by over dehydration of the brain cells. 25% plasma or 50% glucose may also be used.

7. Penicillin should always be used routinely and the patient moved frequently from side to side to prevent a pneumonic condition.

### Summary

1. A brief review of the pharmacological action of barbiturates has been given.

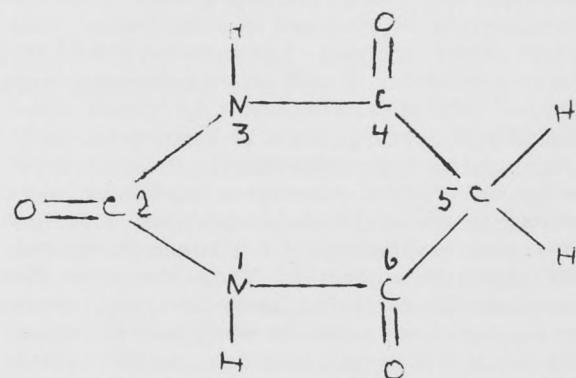
2. Treatment of barbiturate poisoning stresses the adequate oxygenation of the patient with a good airway. The use of early tracheotomy is strongly recommended.

3. The routine use of analeptic and vaso-pressor drugs are not recommended. Penicillin should be routine treatment.

4. A hypertonic intravenous should be used more frequently to combat cerebral anoxia and oedema.

5. Careful attention to the patient until the barbiturate drug is eliminated should resuscitate the majority of these patients.

### Barbituric Acid



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## Hospital Clinical Report

### Victoria Hospital Common Skin Troubles W. G. Brock

Dr. Brock's presentation was of exactly the sort that all presentations should be. He dealt with everyday conditions instead of dwelling at length upon some occult and mysterious disorder. (To the average doctor all skin disorders are occult and mysterious except pimples and, perhaps scabies!) Moreover the manner was as excellent as the matter, because instead of pontificating as he well might have done, he chatted comfortably about a number of most uncomfortable afflictions.

"The first condition discussed was ascending sensitivity. It is not uncommon in dermatological practice to see patients who have been treated for stasis ulcer of the leg, who develop a marked dermatitis of the face, neck and upper extremities, with an explosive onset and an acute course. This results from applying medications which are highly sensitizing. (I still see patients who keep tubes of sulphathiazol ointment for general use.) First Aid Kits often contain this ointment. It is never wise to use sulphathiazol, penicillin, anti-histamine, or local anaesthetic containing ointments. There are better substitutes with low powers of sensitization, for instance, bacitracin, and neomycin ointments. They also have the advantage of not being used internally, hence sensitization to an antibiotic which may be needed as internal therapy at a later date, can be avoided.

"Regarding pruritus ani and vulvae; monilia albicans, vulvitis and vaginitis occur during pregnancy, in diabetics, and not infrequently following the administration of antibiotics for prolonged periods (terramycin and aureomycin). The perianal area may be infected with this yeast in male diabetics, and again after antibiotic therapy. If the pregnant female is not adequately treated, the baby may develop clinical thrush (monilialbicans stomatitis) a week or more after delivery. 1% aqueous gentian violet painted on the affected areas twice daily, if exposed, and less frequently in the mouth and vagina is effective therapy.

"Over-treatment in these cavities results in a toxic contact dermatitis (chemical irritation). Trichomonas causes itching, peculiarly enough some of these patients are itchy in periods of remission. Superficial fungus infections (tinea cruris), bacterial infections (intertrigo), infestations, such as pediculi pubis externally, and pinworms, all are causes of itching. Occasionally the itchy area may present psoriasis or seborrheic dermatitis, etc., although they are not primarily the cause of the itching. Hemorrhoids and other pathological changes in the anal canal may be pain-

ful but do not cause itching. Itching may disappear after a hemorrhoidectomy but it always recurs within three months. Tumors, abscesses, etc., of the pelvis are never the cause of the itching. Drugs sometimes cause itching in this region, even such commonly used medications as phenobarbital and salicylates. Lack of cleanliness as well as local contact irritants are sometimes involved. Nervous stress is by far the commonest cause of itching in this area. This diagnosis must not be made until the above causes have been eliminated by examination. Emotional disturbances are more common than anxieties of a material nature."

Larger in size but still small enough to demand search are pediculi pubis and pinworms. The former, known to the vulgar as "crabs," can cause quite intense itching with all the attendant inflammatory results of scratching. These highly unattractive parasites can be detected more easily with a lens when their nits also will be seen. A clue to their existence in the patient is their co-existence in the marital partner.

Dr. Brock said that the most effective remedy was a powder containing D.D.T. I recalled the incident of the customer who asked a druggist what he should use and was told "Blue Ointment." "All right," said the customer, "give me a pound." "But," said the druggist "that would kill all the crabs in the world!" "So what," answered the customer "I've got them all!" Apparently "blue butter" as the laymen called it, has fallen into disuse as Dr. Brock did not mention it.

Pinworms, as everyone knows, are exceedingly difficult to be done with. Indeed, everything that gives rise to pruritus has a tenacity worthy of a nobler cause. The extremes to which a family may be driven in the matter of washing, changing linen and clothes, etc., are exasperating. Yet without the exercise of the greatest thoroughness these small disturbers of rest and comfort are almost beyond defeat.

A good deal simpler to recognize and remedy is diabetes which is a far from infrequent cause of pruritus in women.

Two drugs in very common use but rarely thought of in this connection are phenobarbital and salicylates. Ignorance of this fact may easily lead to the perpetuation of the ailment if the offending agents are increased or continued in the hope of benefitting the discomfort of which they are the cause.

Indeed, remedies commonly in use may of themselves be responsible for greater mischiefs than they are employed to cure as will be noted later.

When germs, parasites, systemic disease and the rest can all be excluded there remains the

most potent and frequent cause of all—the nervous one. Very many times pruritus is purely psychogenic, and in every case a psychogenic factor is present.

Inasmuch as an understanding of the cause is necessary for its removal, the dermatologist must explain the mechanism of the process as well as devise remedies for its local relief.

Unwittingly, doctors provoke not a few of the skin ailments they are called upon to treat. Many of our most popular remedies are two-edged swords. Thus penicillin and some other of the antibiotics are liable to cause skin eruptions. Bacitracin, it would seem is one of the safest from this standpoint. A good deal of trouble can be spared if one finds out before-hand whether or not the patient is sensitive to these agents.

The "sulphas," also, are capable of causing mischief. Indeed they will even sensitise the skin to sunlight to such a degree as to provoke erythema solare. The antihistamine ointment and those containing local anaesthetics give rise to what Dr.

Brock called "ascending sensitivity" in which the cutaneous manifestations of toxicity or hypersensitivity spread upwards with increasing discomfort.

"In regard to ACTH and cortisone treatment, they seldom provide more than temporary arrest in the course of most diseases and there is little justification for using them except where they may prolong life as in pemphigus, disseminate lupus erythematosus, etc., and infrequently they may be used to carry a patient over an extreme flare-up in a benign disease."

The essence of Dr. Brock's advice was this: Use bland remedies. Bear in mind that anti-histamines, the antibiotics and the antipruritics are capable of provoking hypersensitive reactions. Each case requires investigation of the body as a whole, and psychogenic factors are often the chief ones.

(The paragraphs in quotation marks are Doctor Brock's own).

J. C. H.

## In Lighter Vein

### Diagnosis at Dusk (a story of suspense)

I was on the spot. Six p.m. and no diagnosis. It had to be made and it had to be made fast. I was thinking hard. If I only knew where to begin. Then it hit me. Electrocardiogram, of course! I pressed the buzzer. Amber came in, brisk and beautiful, an eyeful of femininity. But I was in no mood for inspection. "The E.C.G.," I barked, "be quick!" Accustomed to lightning action she delved into the right drawer and handed me the tracing. There was no time to waste. Quickly I glanced over the limb leads and the unipolars. Nothing here. Ah, the esophageal! Staring at me was a tantalizing T wave, not upright, not inverted, just flat. What do I make of it? Nothing definite. Borderline. I threw the record into the waste basket and rang again.

Amber breezed in reeking of Chanel 5. But I was not in the mood for Olfaction. "The x-rays," I roared. Instantly she produced. The films were still wet and dripping. But I was past all caution. I snatched them from her hand and held them up to the Viewer. The chest—heavy roots, tied diaphragms, unfolded aorta. Routine stuff! Barium series—deformed cap? Not quite. Filling defect? Not b... likely. The contrast enema—a small diverticulum. Or is it a fecolith? As if it matters! The intravenous pyelogram—are the calyces clubbed? Not much. The retrograde pyelogram—disgustingly normal. The K.U.B. and gall bladder visualization even more so. No help here. I threw the films out the window. I rang again.

Amber waltzed in wearing a red tight-fitted sweater. But I was not in the mood for palpation. I was faced with a dilemma. Blood or urine? Quickly I made a decision. "Blood chemistry," I shouted. Promptly she brought in the file. Glucose tolerance curve—flat? Not too significant. B.U.N.—upper limit of normal. Urea clearance—lower border of normal. Serum sodium, serum potassium, serum calcium, serum chloride, and serum cholesterol—all normal. A hateful word. Serum magnesium—not even mentioned. My lab must be slipping. I was getting nowhere fast. Where were the blood counts smears, and sed. rates? I reached for the buzzer again.

Amber shimmied in. I could see her bosom heaving with each heart beat. But I was not auscultating. I had a job to do, and I had to do it fast. "Blood morphology," I commanded, "and throw in the sternal marrow." Breaking the sound barrier she threw the reports on my desk. Normal and borderline again. Not a hint.

Before I had time to summon her, as if reading my mind, Amber slunk in with more reports. Then she slapped my face. That girl could read my mind all right. But I wasn't being sidetracked. Quickly I glanced through the urinalysis, the C.S.F. report and the B.M.R. Nothing there. Vital capacity and circulation time—within normal limits, E.E.G.—alpha rhythm. I was stumped. I was stymied. Where do I go from here? There was nothing left for me to do, unless? Yes, I knew it had to come. The thing I dreaded—a physical examination. I rang again.

Amber tiptoed in, her crimson lips pouting. But I was in no mood for osculation. "Bring in the patient," I whispered hoarsely, "stripped for examination." Sensing my tension she darted out and returned with the patient in a wheel chair. I could hardly believe my eyes. "Not you," I cried, "it's the patient who is to be stripped." Quickly she unveiled him. Reluctantly I proceeded to examine. What a chore! The patient was not co-operating. He cried when my finger nails dug into his right upper quadrant. He kicked when the sharp blade of my pocket knife stroked his sole for a Babinski. He swore when the reflex hammer hit him hard on his patella. He screamed when my ear speculum touched his ear drums. He jumped sky-high when I tested his testicular sensation with my forceps. He was hostile throughout. But I was past caring. I had a diagnosis to make and it eluded me. The stethoscope was bringing in unpleasant noises. Must be the rustling of the interposed shirt. I was defeated. I was deflated.

Then it happened! Amber undulated in noiselessly. My head was swimming. But I was keeping it above water. She sensed the drama within me. "How about a history, Doc?" she whispered caressingly into my ear. This I never thought of. Repugnant as it was, I knew it was my last hope. Harsh realities call for harsh measures. I braced myself for the ordeal. With jaws set, through clenched teeth, I spat out: "What is your trouble?" The answer was a bombshell. "This is not what I came here to find out," he said without batting an eyelash. "What then did

you come here for?" I cried utterly exasperated. "To get a Premarital blood test," he said, "I'm getting married next week." Stunned by his reply I glanced quickly through the reports. Everything was done. Everything but a blood Wasserman. I broke out in a cold sweat. My hand shook as I pressed the buzzer again.

Amber strode in, vibrant and exciting, a burning volcano. I extinguished it fast. "Where's the Wasserman report?" I thundered. She paled, she trembled, she mumbled excuses. But she knew and I knew that it was all over between us. What happened was bigger than both of us. No one can omit number 38 routine lab test and stay on. She put on her coat and gloves. Tears were streaming down her cheeks. "So long, Doc," she sobbed, "it was fun while it lasted." I blew my nose. I bit my lip. I said nothing. Something big and important had gone out of my life. . . .

I looked at my watch. My heart sank. The effort was wasted. It was late. Much too late to make the Dinner Meeting of the Medical Historical Society.

**Editor's Note:** What a ridiculous excuse to give for failing to attend an important meeting!

After having pitched your various records hither and yon you should have first chucked the girl under the chin and then under the table; after which you would have thrown out the patient who—you have apparently missed this—was going to marry your precious Amber.

The reason why she forgot the W.R. is perfectly obvious—what was the report on her own?

## Fugitive Pieces

J. C. Hossack, M.D., C.M. (Man.), Editor

### VI. Janus and January

It was a Roman idea to make January the first month of the year, but although there was a popular regard for the first of January to be the first day of the year, the older date—the 25th of March—persisted to be the first day of the legal year until 1752 and even later. In fact even now the fiscal year as marked by the introduction of the budget begins about that time.

Numa Pompilius, however, who did a bit of calendar making, decreed that the year should start now and dedicated this new month to Janus who was a versatile deity with a special interest in doors (*janua*—a door).

Janus' second name was variously "Bifrons"—two-faced, or "Biceps"—two-headed. This anatomical peculiarity enabled him to look two ways at once; and it was for this reason he could look backward and forward into the years—that Numa picked him for the first month.

Like most of the pagan gods Janus was kept quite busy one way or another. Doors and locks were his invention and when anything went wrong with either he was invoked under the name of Janitor. Perhaps it has never occurred to suite-dwellers that the reason why janitors are sometimes "snooty" is because they have divine attributes!

In his pictures he is usually shown holding a key. This particular one is emblematic of his office as door opener upon the gods. A suppliant had first of all to say a prayer to Janus who then opened communications with the deity whose attention was requested.

He had a temple of his own in which was his bifrontal or bicipital image. Here the consuls were inaugurated, and services were conducted in his twelve chapels. The doors remained open in times of war and it is interesting to record that they were closed only three times in the course of

seven hundred years. The last occasion was after the victory of Actium but as lesser wars continued to be waged the doors may well have remained open for a millenium.

If Janus looked a bit odd it was because he took after his mother. As was not unusual for the deities of the time she went under a variety of names, three especially. In the heavens she was called Luna; on earth, Diana; in hell, Hecate. As Hecate she did not spend all her time in the Infernal Regions and when she wandered abroad she could not pass unobserved because she had three heads, one human, one equine and one canine. Just to make her a little more odd she sometimes was pictured with the head of a lioness in place of the human one. Moreover she was sometimes given the body of a dog. From all this it is fairly safe to assume that her sister goddesses affectionately referred to her as "that three-faced bitch."

As Diana she was beautiful and chaste. As Luna (varied to Lucina) she is of interest to obstetricians for she practiced their "art" and was invoked by the parturient. Her midwifery was, however, limited to one case—her mother. The story goes that as the first of twins she assisted in the delivery of her brother (Apollo). Probably she had an extra long cord, or bit it off or something. But Latona, her mother, apparently had quite a rough time and after all an hour-old kid couldn't help much, and Lucina was so affrighted by her mother's pain that she swore right then and there that she would remain a virgin! Thus two-thirds of the Luna-Diana-Hecate complex were sworn to chastity. Hecate, who had taken no such vow became the mother of Janus. Incidentally he also got into the act—he opened the door of life to the new-born.

And so we come back to Janus and January again. Happy New Year!

### VII. More About Mirth

First of all let us have the letter. It is a criticism of an item published in the November number under the heading "Memory and Mirth." To the Editor:

Sir:

The conclusions drawn by J. C. H. in "Memory and Mirth" from the audience reaction to the film "The Octopus Remembers," shown by Professor F. Young in the course of his memorable address, cannot be allowed to pass unchallenged. J. C. H. states that "mirth is a pleasure-pain reaction, one man's pain gives other men pleasure." That humour is a by product of sadism is a view widely held by many authorities on the subject. Nonetheless, I find it difficult to subscribe to it. True, I recall an occasion on which I was convulsed with laughter at the sight of my neighbour slipping on a banana peel, that I had carefully placed in front of his doorstep the night before. But then,

my laughter ceased abruptly, the instant I realized that the poor old man fractured his femur. Similarly, on another occasion I remember splitting my sides laughing at the discomfiture of a portly middle-aged gentleman who slid noisily to the floor, as my deft hand snatched away the chair on which he was about to sit down. But then again, how was I to know that the unfortunate victim of Newton's law had only recently undergone an operation for pilonidal sinus? Anyhow, at the time I was only a boy of thirty-five, and my reaction could hardly be regarded as manifestations of an adult sense of humour.

No. The intelligent, high I.Q. audience that watched with bated breath the adventures of the Octopus laughed not because poor Octy was in trouble, but because he was funny. We are all familiar with other animals of memory fame: the elephant who never forgets, the lion who remembered Androcles, the nightingale who inspired the romantic song "The Nightingale Remembers." None of them were ever known to provoke laughter. But the clumsy, pathetic Octopus moving about in a tank full of water will elicit a chuckle even in those who prefer their humour dry. Everything about the Octopus, the Octopic rhythm of his movements, the grotesqueness of his Octopic organs, is nothing if not mirth provoking. The accentuation of the laughter, indeed the transition from a chuckle to a belly laugh that accompanied each retreat from the electrically charged plate, was due to the added element of sudden surprise, the reaction to the unexpected rather than the enjoyment of pain.

It is this, more charitable view of humour, that Voltaire must have entertained when he said: "Laughter always arises from a gaiety of disposition, absolutely incompatible with contempt and indignation."

S. V.

P.S.—Is it true that another film titled "Octopic Pregnancy" will be shown soon by the Department of Obstetrics? If it is, it will be a smash hit.

S. V.

### Quid Dides?

I am always glad to get letters from my readers even when these are critical. I must admit that, at times, I am perplexed by my correspondents' inability to see what is perfectly obvious to anyone free from bias. The latest occasion is Dr. Vaisrub's letter published herewith. Nothing could more strongly prove my point. He was "convulsed with laughter" when he watched his octogenarian neighbour slip on the banana peel so carefully placed by Dr. Vaisrub himself. How fortunate it was that his victim did not already have one foot in the grave before putting the other on the banana peel! In such a case the result, I am sure, would have reduced Dr. Vaisrub to status epilepticus.

And then there is the other dastardly incident where he plucks the chair from under a portly and elderly gentleman whose bottom is still sore from the work of a surgeon. How vastly would Dr. Vaisrub's merriment have been increased had only the gentleman in question suffered from haemorrhoids in a state of strangulation! If his laughter ceased abruptly, as he says it did, it was not by reason of pity or remorse but out of fear of retaliation and a sense of jeopardy.

Naturally the fact that a creature can remember is, of itself, no cause for mirth. We envy the elephant for his memory; we do not laugh at him for his possession. There is nothing amusing in the fact that the lion remembered the kindness of Androcles or in fact that another lion was remembered by a mouse. But I am a bit surprised that Dr. Vaisrub's perverted sense of humour does not find the nightingale a subject to his liking.

Let me remind you of the story of Philomela in case you have forgotten. She was the sister of Procne and therefore the sister-in-law of Tereus, King of Thrace. Philomela, on a visit to her sister, inflamed the barbarous Thracian with an irresistible passion. He violated her person, immured her in a far-distant hut and cut out her tongue so that the truth might remain concealed.

But "murder will out." In her prison Philomela wove a garment and in it she wrought words that told of her plight. This she sent to Procne by a trusted messenger. It was the time of the Bacchanalian Festival and, taking advantage of the liberties it afforded, Procne sought out her sister and freed her.

Then came their revenge. Procne had borne to Tereus a son called Itys. Him they slew, cooked in a dish and served to his father who, after he had eaten, was told of what he had eaten. In fury Tereus seized a hatchet and pursued Procne who would undoubtedly have been killed had not all three been changed into birds. Tereus became the hawk, Procne the swallow and Philomela the nightingale.

What a jolly little bed-time tale! So many surprises to so many people and all of them so dem'd disagreeable! Ha! Ha! Ha! And Dr. Vaisrub wouldn't be the first to see the joke. For Fletcher wrote:

"Philomela perched on an aspen sprig,  
"Weeps all the night her lost virginity,  
"And sings her sad tale to the merry twig,  
"That dances at such joyful mystery"

Dr. Vaisrub would have us believe that it was the appearance rather than the reactions of Octopus that caused the laughter. Than Octopus there is no creature less qualified to evoke mirth. It is a hideous, repulsive, fear-inspiring monster. I repeat again, there was no show of amusement during the earlier scenes of the film when Octopus was

undisturbed. The grotesqueness of his "octopus organs" was obvious from the beginning and didn't raise a smile, nor did it alter in the slightest degree the quiet rhythm of anyone's abdominal muscles. But when the brute was hurt, when suffering and in fear it fled to the pitiable slight protection of its rude, comfortless and miserable hovel, then it was that the highly intelligent audience threw up (metaphorically) their sweaty nightcaps and began, en masse, vigorously to massage their abdominal viscera.

For the audience there was no "sudden surprise," no "reaction to the unexpected." They knew what was going to happen just as Dr. Vaisrub did when he saw his aged victim step on the banana peel. It was the poor subject of investigation that was surprised so disagreeably; and the audience, instead of gravely looking upon the reaction as a scientific phenomenon, let go with bursts of sadistic hilarity.

I do not question the accuracy of Voltaire's definition. Certainly here was neither contempt nor indignation and here, also was an expression of gaiety of disposition. But people have different dispositions and therefore different ways of expressing their gaiety. The little boy who chuckles as he pulls their legs off flies exhibits his gaiety of disposition just as Dr. Vaisrub did in his youth when he put pepper in his grandmother's coffee and gunpowder in his grandfather's pipe. In the matter of Octopus as in these other examples not Euphrosyne but the Marquis de Sade was the instigator of the mirth that followed.

## Victorian Order of Nurses

### Doctor — "Take it Easy"

That homely philosopher Mr. Dooley once said:

"Sometimes it doesn't matter very much what sort of Doctor you have if only you have a good nurse."

Perhaps he was thinking of **heart disease**. The care of a cardiac patient certainly calls for all the intelligence, skill, resourcefulness and comfort that any nurse can offer. We nurses can't quite go along with Mr. Dooley. We realize that the patient gets maximum benefit when the Doctor, nurse and family are able to work together on a plane of mutual respect, understanding and sympathy. Medical and nursing care can be successful only to the degree that the patient is responsive to it. Sometimes the patient does not carry out the steps that are outlined to him. It is then necessary to persuade him. The nurse's place here is to collaborate effectively with the physician, either in finding the reasons why the patient does not follow his instruction, or to persuade him to do so.

To get back to our cardiac patient, we felt the following paragraph from "Just Plain Nursing" was apt, and we thought it would interest you:

"From time to time most nurses overhear a Doctor light-heartedly telling his patient that he must "slow down and take it easy." While giving this sage advice he usually keeps his hand firmly on the door knob ready to escape questioning, partly because he isn't sure that the patient can possibly carry out the prescription and, partly because he's late for the office and doesn't want to hurry too much—the incidence of coronary accidents among physicians being what it is. So—off he goes. Meanwhile the expression on the patient's face betrays some anxiety and since he isn't quite ready to talk things over with his family he turns to his nurse instead."

The home visiting service of the Victorian

Order of Nurses can help you with patients such as this. This patient belongs in a class where physical activities and emotional tensions ought to be restricted. He needs help to lead a normal life but must avoid placing undue strain on an uncertain organ. He needs reassurance and comfort from both his doctor and nurse. Often in placing a call to the Victorian Order of Nurses the doctor adds:

"Try to give this patient moral support."

We appreciate his understanding of both his patient and of our nursing function. We are anxious to help you in every way we can.

Since with your superior knowledge you have a better understanding of his physical condition and emotional needs we appreciate your guidance in this respect as well as your precise instruction as to nursing care.

THE VICTORIAN ORDER OF NURSES

Call 92-8529

## Book Reviews



**Clinical Orthopaedics** is a profusely illustrated volume of 242 pages. This is the first number of a new bi-annual the purpose and scope of which is best given in words from the Preface.

"Essentially, this Preface to the first issue of Clinical Orthopaedics is the introduction of this new publication to the medical profession. This organ is sponsored by the Association of Bone and Joint Surgeons and is a concrete expression of what is in the minds of many orthopaedic surgeons. Most of us are keenly aware of the need for additional outlets in the literature for material of orthopaedic interest; also, it is generally known that the existing journals are swamped with good material which, because of the lack of space, is denied publication. As a result, the findings of valuable investigations are published in journals conceived primarily for general surgery; hence they are lost to those truly interested in them. In addition, the English-speaking countries do not have an organ capable of providing avenues of expression for the ever-increasing subdivisions of orthopaedic surgery and the allied specialties. Finally, no concerted efforts have been made by the orthopaedic group as a whole to keep the general practitioner and the surgeon in allied fields abreast of the rapidly growing scope of orthopaedic surgery and its numerous ramifications. It becomes apparent that a serious need exists for a publication which will fulfill the aforementioned needs and provide for the groups concerned the means whereby material of scientific, practical and academic value can be disseminated not only to orthopaedic surgeons and traumatic surgeons but also to all those in the

allied specialties and, above all, to the general practitioner.

"Clinical Orthopaedics appears in book form. For the present, two issues a year are contemplated; however, the number of issues per year may be increased, depending on the number of worthy articles submitted. Essentially it is divided into two parts, the first part devoted to the consideration of a specific topic. This issue deals with certain problems pertaining to children's orthopaedics. (In the following issue (Fall, 1953) the timely topic of intramedullary nailing will be presented. The second part will contain miscellaneous articles dealing with subjects of interest not only to the orthopaedic expert but also to the general practitioner and to those in allied specialties. It is hoped that the second section will be utilized as a means of intercommunication between the special fields of surgery, as a source of practical information by the general surgeon and practitioner and as an avenue for the dissemination of accepted and new information in inter-related fields."

The contents are in two sections. Section One is on "Children's Orthopaedics." The chapters are on Arthritis; Flared Ribs; Clubfoot; Perthes' Disease; Supracondylar and Transcondylar Fracture; Femoral-Shaft Fractures; Posture; Scoliosis; Tuberculosis of the Spine; Trigger Thumb, etc.

Section two is on General Orthopaedics. Some of the topics considered are: Backache and Sciatic Pain; Nonunion of the Tibia; Ewing's Tumor; Metatarsal Resection for Disanilities of the Foot; Flatfeet; Paget's Disease; Myositis Ossificans.

**Clinical Orthopaedics:** Anthony F. DePalma, Editor-in-Chief, with the assistance of Five Associate Editors and a Board of Six Advisory Editors. Number One. J. B. Lippincott Company, Canada. Price sustaining orders \$5.00 per copy. Single copies \$6.00.

**Respiratory Diseases and Allergy:** This eighty-page booklet is described as "a new method of approach to respiratory ailments." The author undertakes to prove that "twenty-odd syndromes now described in all text books as separate diseases are only manifestations of one disease" which he calls "Respirallergy."

He "demonstrates a method of preventing and neutralizing the evil effects of this disease" and "reveals the discovery of a method which obviates the customary routine of testing each patient for each allergic substance."

This vastly simplifies pulmonology both as to diagnosis and treatment. But such oversimplification is likely to be caught in its own snare. The author assures us that his statements and claims are made on the basis of "factual results of successful work for many years" and that "any physician following the text of this book, which requires no specialist's skill, should get the same satisfying results."

As there is no reason to distrust the honesty and sincerity of the author, no harm can be done by following his instructions. He gives no case histories or statistics so that each one will have to prove the pudding for himself.

A good deal of the information is elementary and in the treatment of pneumonia and other infections he relies on the standard remedies. His principal contribution is on "Respirallergy" for which state, he claims, his simple technique of treatment proves almost universally satisfactory.

**Respiratory Diseases and Allergy: New Method of Approach** by Joseph S. Smul, M.D., Author of Digestive Diseases and Food Allergy. Fellow National Gastrointestinal Association, Member, N.Y. Academy of Sciences, etc. New York Medical Library Company, 1953. Price \$2.75.

### Dr. Pitcairn Witnesses an Accident

Doctor Archibald Pitcairn of Edinburgh not only was the first to call attention to the changes wrought by rheumatism in the heart but had his own ideas as to the etiology of disease. Furthermore, as a good Scotsman, he was well versed in the Bible which he could, on occasion, quote most aptly.

The story is told that seeing a poor fellow killed, by the fall of a chimney which he had just been building, he said profanely "Blessed are the dead that die in the Lord; for they rest from their labours and their works do follow them."

**Handbook of Differential Diagnosis,** by Harold Thomas Hyman, M.D., Author of "Integrated Practice of Medicine." 716 pages. J. B. Lippincott Co., Medical Arts Building, Montreal. Price \$6.75.

For several reasons this book should be very popular. First of all it is compact and concise. Then the contents are arranged so conveniently that the required information is quickly made available. The author describes the descriptions as "telegraphic." They are brief and to the point and often comparisons are made by way of tables.

The index comes (where every index should come) at the front and on colored paper. There are 1,585 symptoms and signs listed "reference to any one of which directs the reader to some one of 232 divisions of differential diagnosis, alphabetically arranged."

Semi-marginal headings and variations in styles of type form helpful guides. There are many cross-references which save the reader from having to turn again and again to the main index.

It is a tip-top book.

### Clinical Luncheon Program

The Winnipeg General Hospital

- Jan. 7—Department of Obstetrics and Gynaecology.
- Jan. 21—Department of Pediatrics, including Neo-Natal Service.
- Feb. 4—Department of Dermatology.
- Feb. 18—Department of Neurology and Neuro-psychiatry.
- March 4—Department of Neuro-surgery.
- March 18—Department of Pathology.
- April 1—Department of Physiology and Medical Research.
- April 15—Department of Radiology.
- May 6—Department of Medicine.
- May 20—Department of Surgery.

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## Medical History

### The Third Book of the Chronicles of the Medical History Club

#### Chapter I

1. Now when it became known abroad that our fellowship had been revived there was a stirring of the brotherhood; and so it came to pass that in the ninth month and on the three and twentieth day thereof there was a gathering of the brethren.

2. And we gathered as in times past in the House of the Physicians and broke bread and did eat.

3. And the names of them who were of us are these: Ross surnamed Mitchell, and Ian son of Thom, and Jaydee son of Adam, and Dwight son of Parkin, and Paul son of Thorlak, and that other Paul which is called Green, and David called Swartz and Simon Ben Jauvoish.

4. And Paul which is called Green brought forth a bottle of wine of a rare vintage, and we drank thereof and were refreshed, and the joints of our tongues were loosened and we looked upon one another with gladsome countenances.

5. And when our hunger was abated I, John, rose in my place and spake unto the brethren saying: Behold, it is needful that we chose from our number one who shall be our ruler.

6. And I spake further saying: There is with us even now Ross called Mitchell who hath been of our company since the beginning. What say ye that he shall be our ruler? And the brethren cried in a loud voice and as one man: So let it be. And it was so.

7. Now when all things had been accomplished we went into the great chamber and set down therein that we might hearken unto the discourse.

8. And when we were seated there arose in his place Ross which is called Mitchell and he opened his mouth and spake unto us saying: Men and brethren. It is a goodly thing that hath come to pass among us for verily our brotherhood liveth again which is a pleasing thought.

9. And we have come together as hath been our great hope. Let us not again permit this thing to wither but so tend it that it may flourish forevermore by reason of our careful husbandry.

10. And when he had made an end of speaking he said unto Paul that is called Green: Stand forth I pray thee and speak unto us thy discourse.

11. Then did Paul which is called Green stand forth in the company and he spake upon a matter. Now the matter whereon he spake may seem a strange one for such a gathering for it was of these small pieces of paper which men call stamps.

12. And he showed unto us many such, and upon them were graven the likenesses of gods and

of men and other such things as had to do with healing.

13. Now even while he spake the door of the chamber was opened and there entered Dorothy the wife of Joseph and we greeted her yet not with an holy kiss for her husband Joseph was not with her and might have been wroth, sobeit that later these doings should come unto his ears. Yet we rejoiced to see her for verily our craft is ennobled by the women who are of it. And sundry others entered also that our number was enlarged.

14. Now Paul beginning with the gods, even with Apollo, shewed unto us many likenesses and we marveled at the art of the engravers for verily they were cunning workmen.

15. And the likenesses were of many men of many lands and of all times and we were astonished that so many should be so remembered. Yet were there none of them of our own kindred, for in the realms ruled over by the young Queen it is not seemly to put upon such stamps any likeness save that of Majesty.

16. Now among them honoured in this fashion were many physicians and among them a woman. Yet was there no likeness of any cheirurgeon. And methought wherefore should this be? And there came an answer into my mind: Peradventure the gravers have suffered at their hands or been impoverished by the payment of their charges wherefore they said unto themselves: Let us give no honour unto any such.

17. Now when Paul had made an end of his speaking he seated himself and the brethren discussed upon the matter.

18. And verily they learned much about them whose likenesses they had seen but more about the collecting of such pieces of paper whereof the name is philately.

19. Now this word cometh from the Greek for phil meaneth lover and ateliea meaneth freedom from taxation; so that the word, being interpreted, meaneth lover of freedom from taxation. The which is a love that many possess but that can only thus be satisfied; which peradventure explaineth the number of them that do so.

20. Yet the rulers of the world know of this craving in men's hearts to gather things unto themselves, and make many stamps beyond the number needful. And this they do to make gain for themselves so that many in their folly pay much tribute.

21. For when a new stamp appeareth they run in their thousands to possess it, and of the making of many new stamps there is no end the purchase thereof exhausteth great riches.

22. And Paul told us of these things and of how the likenesses of houses and towns and scenes of

desolation were placed on these stamps so that no man might have any peace who gathered them, for verily he is as one upon a treadmill.

23. Now when there had been much conversing for a season the brethren prepared to depart; and one of them seeing that the flask of wine was not emptied said unto the others: It is not seemly to leave this so, therefore let us dispose of it in token of our fellowship.

24. And when they had done so they departed.

## Chapter II

1. Now it came to pass in the second year of the reign of the young Queen in the eleventh month and on the eighteenth day of the month that there was a coming together of the brethren. And they gathered in the House of the Physicians in the appointed place and did break bread as afore time.

2. And in the seat of the ruler of the feast was Ross called Mitchell who hath been our ruler since the time of our revival.

3. And many brethren sat down with him even to the number of a score and one. And these be the names of them who broke bread and afterward hearkened unto the discourse; even Ian son of Thom, and Alec son of Gib, and Dwight son of Parkin, and Noel son of Raw;

4. And Paul son of Thorlak, and Paul which is called Green, and that other Paul which is called White (he who knoweth by name the amides and the amines and the like).

5. And Simon Ben Jauvoish and David called Swartz (the same is Ruler of our Fellowship), and Walter called Tisdale who is Chief Ruler over all the physicians in our land; and Condron which is called Strong and who was aforetime a rider of horses like unto whom there hath been none such since the day of Jehu;

6. And Alvin called Mathers who was in times past Chief Priest in the temple and from whom nothing is hid that concerneth the id and the ego and the super-ego for he knoweth all that passeth in men's hearts. And Donald called Bowie who is a cutter-up of the dead, and Walter called Alexander. And he it is that gazeth into the eyes of maidens and sayeth unto them: Behold thou hast need of glasses;

7. And John called Gunn and Fred whom the years touch not and they have been of the brotherhood since the beginning. And Allan called Klass, and Harry called Lander, and Charles called Walton, the same that easeth them that wheeze and sneeze, and Tom called Lebetter even he who understandeth the movements of the heart. And I also was of the company.

8. And we rejoiced exceedingly that the number of the brethren should be so great for verily it hath not been so since the evil men brought woe upon the world in the days of the Good King.

9. Now when the brethren had made an end of eating they prepared to hearken unto the discourse. Then did Ross called Mitchell rise in his place and he spake unto us saying:

10. Men and brethren, behold we are gathered together to hearken unto Ian son of Thom whom ye all know to be one that speaketh fittingly upon all matters that pertain unto dead corpses, for great be the number thereof that he hath cut asunder.

11. And he will discourse upon others of like habit with himself who brought glory, even though it was but that of the sepulchre, upon the City wherein they laboured.

12. Then did Ian son of Thom stand forth in the company and spake unto us; and verily the words he uttered, are they not to be found in their proper place?

13. And Ian son of Thom shewed unto the brethren the likenesses of them whereof he spake and David called Swartz helped him so to do. And the brethren hearkened attentively for verily his words were pleasing to their ears and enlightened their understanding.

14. Now, as I hearkened I asked of myself: wherefore do some men accomplish so much and others so little albeit their lives be longer?

15. And methought, likewise, how cometh it that for a while glory shineth upon a place and then passeth away or fadeth so that there is left but a glow where once there was a flame. Yet, verily, so hath it been in all generations and in all lands since the beginning.

16. Yea, upon the portals of Padua and Bologna and Salamanca and like great and famous cities is inscribed Ichabod for verily their glory hath departed; Even as it hath departed from Tyre and Nineveh and from the cities of the Nile.

17. For it is as if their lamps had but a measure of oil, the which was consumed. Yet the lamp perisheth not but goeth from one hand unto another and is replenished for a season.

18. And so it passeth from cutters of stone in one place unto cutters of the dead in another place and from them to those who sing and make music or fashion strange things that do move in the heavens and on the earth and in the deep waters.

19. Yet the light which once shone lighteth up many and they bear it with them for a season and others are thereby nourished in their understandings; Even as them whereof Ian son of Thom did speak and who found out many hidden things, which by them have been made known unto all men.

20. For they were men of learning and wise in their instruction, furnished with ability and honoured in their generations.

21. Now when Ian son of Thom had ended his discourse unto us there was a great clapping of hands. And the brethren rose from their places

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and mingled and looked upon the books written by those whereof they had been told.

22. And verily some of the things writ therein were of a freshness as of yesterday and we marvelled thereat.

23. And when all these things had been ended we departed. And it was the ninth hour.

### Dr. Abernethy Proposes

John Abernethy (1764-1831) was one of that numerous band of Scotsmen who migrated to London there to become a leader of the profession. He was brusque, often rude, especially towards his many rich and noble patients, but capable of infinite tenderness and consideration when he attended the poor. His name still lives in the "Abernethy Biscuit" which people buy daily and the interesting origin of which may be our topic later. What we have in mind now is the story of his courtship of his wife, if courtship it can be called.

While attending a lady for several weeks he observed those admirable qualifications in her daughter which he truly esteemed to be calculated to make the married state happy. Accordingly, on a Saturday when taking leave of his patient he addressed her to the following purpose: 'You are now so well that I need not see you after Monday next, when I shall come and pay my farewell visit. But, in the meantime, I wish you and your daughter seriously to consider the proposal I now am about to make. It is abrupt and unceremonious, I am aware; but the excessive occupation of my time, by my professional duties, affords me no leisure to accomplish what I desire by the more ordinary course of attention and solicitation. My annual receipts amount to £\_\_\_\_\_ and I can settle £\_\_\_\_\_ upon my wife; my character is generally known to the public so that you may readily ascertain what it is. I have seen in your daughter a tender and affectionate child, an assiduous and careful nurse, and a gentle and lady-like member of a family; such a person must be all that a husband could covet, and I offer my hand and fortune for her acceptance. On Monday, when I call, I shall expect your determination; for I really have not the time for the routine of courtship.'

"In this humour the lady was wooed and won and the union proved fortunate in every respect."

Chambers "Lives of Eminent Scotsmen."

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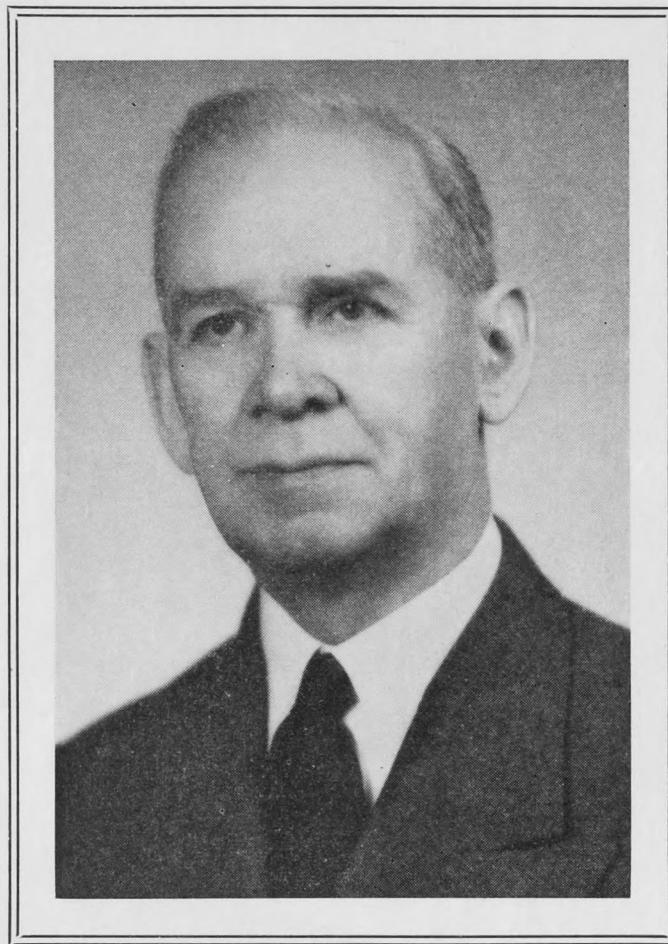
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I must have seen him earlier but the first time I conscientiously associated the person of Walter Tisdale with his name was one evening in my first year in College. Then someone said "There's Walter Tisdale," and I looked very attentively for not only was he a year ahead of me but he was a scholarship man.

Now everyone knows that a freshman is regarded by all other students as little better than that ancestor of ours who was the first to squirm from the primeval ooze. And to such a lowly creature a student even a year ahead is someone grand and, if he has won a scholarship, someone great.

Being of Scottish ancestry and having once won a scholarship Walter saw no reason why he should pay fees so long as the late Mr. Isbister's money lasted. Thus it became a habit with him to win scholarships; and, each year when the results came out, the question asked by the students was not "Who won the scholarships" but, "Who won the other scholarship?" There being no such award in the Fifth Year Walter had to be content with the two gold medals.

He graduated in 1917 in a special class, for doctors were needed overseas (the War being then in a critical phase) and he remained in France until the end of hostilities, taking part, among other engagements, in the Battle of the Marne.

Just before this important clash of arms — while awaiting its beginning — he heard a sound that quite wiped out the noise of battle. Years later he described it thus: ". . . was a grove of trees. From this copse came the most beautiful voice I have ever heard. I realized that I was listening to my first nightingale. I was listening to that voice of such exquisite beauty that legend tells that Death once heard it and stayed his hand. The sound of guns is dim in my memory, but the song of the nightingale is as if I heard it last night."

There is a world of revelation in these words; for one who cannot hear the thunder of guns when a bird is singing must be equally deaf to the dissonances of daily life, equally alert to Nature's harmonies which, though everywhere about us, our ears are not always tuned to hear. It is an enviable quality, for it leads to inward peace and outward calm.

After returning to Canada he served for two years with the Red Cross. Just after the "First" War there came into being several settlements, small and scattered, which were populated by returned soldiers and fringed the sparsely inhabited northern part of the Province. In these the Red Cross set up posts or stations which were served by a single doctor who visited them in turn or as occasion demanded.

The position was an excellent one, though not greatly remunerative, because it gave an unequalled opportunity to study people and to develop initiative. Here a doctor had to be his own assistant, his own specialist, his own consultant; and here he could see and understand, in part at least, how dependent function is upon feeling and how dependent feeling is upon environment and way of life. It is well for doctors to learn early in life that patients are persons who need guidance as much as medicine or the knife.

In 1924 he began practice in Winnipeg. His mastery of the "bookish theorick" he had shown in College. His activities after graduation had furnished knowledge and experience. Nature had given him a pleasing personality and the ability to inspire confidence. With these attributes success was inevitable. He did not attach himself to any special hospital though for a time he served in the Out Patient Departments of the Winnipeg General and Children's Hospitals. Later he became associated chiefly with Misericordia Hospital. Nor did he become active in our political life until 1942 when he was elected Secretary of the Winnipeg Medical Society. After two years in this office he was elected Vice-President and then President. In 1949 he was elected to the Executive of our Association as Member-at-large. Next came the Vice-Presidency and now the Presidency.

Walter was born "away back" in 1887 but he doesn't look it. His father was a United Empire Loyalist whose family had been resident in America about a century and a half before the emigration. He was born on a farm near Baldur, the fifth of eight children, and after the usual schooling entered College in 1913.

As character is formed in the earliest years of life it was on the farm that "Nature, that dear old nurse, took this child upon her knee" and opened for him her book of marvels. How close his "dear old nurse" is to his heart was shown in his address as retiring President of the Winnipeg Medical Society. In it he told of the beauties, the pleasures, the comfort, the inspiration that comes from her study. There is something purifying and exhilarating in the coolness of the dawn; something infinitely restful in the solitude when night reigns and the silence is scarcely broken by the careful movements of little animals about their business. Years of such experiences spoil one for the raucous din of the market place.

Now, as Walter is extrovert enough to be a surgeon, we would naturally expect him to be a hunter. In their leisure moments surgeons almost invariably either play with hammers and saws or wander about in forests and fields looking for something to kill. This is, of course, their way of sublimating their innate hostility which cannot completely be relieved by shedding blood in operating rooms!

Walter, in common with surgeons in general, has his moments when he wants to smash and slay. But he has found a nice middle way whereby he can, as it were, kill without killing — he shoots clay pigeons and "bull's eyes." Moreover he must be quite good at it because he held the championship for a time, and incidentally, added to his collection of medals.

Shooting and Nature-study are, however, scarcely parlour amusements. Within the quiet of his home, and without it also, he takes pleasure in music and, judging from his Address, in poetry as well. To my mind, one of the causes of the World's woe is that not enough people read enough poetry. Milton knew whereof he spoke when he said "And ever against eating cares lap me in soft Lydian airs Married to immortal verse."

Both Walter and his wife have been keenly interested in music for many years. But they have been equally interested in Art in its other forms. Beauty whether in line in colour in movement or in sound has for them an irresistible appeal; and they have ardently and generously supported all the organizations which supply them with so much pleasure.

This introduces Mrs. Tisdale who took Walter in hand in 1927 and properly has a place here because, whatever they may think about it themselves, husbands are very much the handiwork of their wives. "A good wife," you will remember, "makes the best husband!" I have no doubt that Mrs. Tisdale will modestly disclaim any responsibility for her husband's success, but as she will be in a minority of one her opinion on the matter is of no importance!

Kindliness is a higher attribute than skill, for skill can be acquired but kindliness is instinctive. Concern for others marks the generous person and not a few members of our profession and their dependents have reason to be thankful for Walter's thoughtfulness. The Benevolent Fund was his idea and he played a very large part in bringing it into being.

Such then is the record of our new President. Clear-headedness, impartiality and industry which he has shown in the past will without doubt be applied to our benefit during his term of office. Because we are so sure that he will work for us, the least we can do is work hard with him.

—J.C.H.



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## Editorial

J. C. Hossack, M.D., C.M. (Man.), Editor

### The Open and the Closed Hospital

There are some people who honestly believe that only in a "closed" hospital can patients be properly attended. Moreover, in their efforts to raise their standards or to meet official requirements, hospitals tend to be increasingly critical of those who use them. Practitioners thus find their activities undergoing circumscription and that at a time when they are striving more and more to improve themselves.

Not long ago one of the local hospitals informed the doctors who used it of the limits which a committee had set upon the scope of each one. This tactical error was quickly corrected, and while there had been no explosion the lingering smoke showed that one had barely been averted.

It is obvious that hospitals must have standards and that the public must be protected. But every qualified doctor is licensed to practice medicine and surgery without any restriction being set upon what he may do in either. It is an anomalous situation where a body not established by law can take away what the law has given. The law demands no more than a reasonable amount of skill, knowledge and care. No one is better able to decide in any case when these are present in adequate degree than the individual doctor. Until a legally established body is brought into being (or a body which he himself has had a hand in establishing) eligibility committees have the invidious task of passing judgment upon those whom the law already accepts.

The general practitioners are very sincere and very serious in their desire to improve themselves. They will do much private study. They will attend meetings here and elsewhere. But on the whole it is of little profit to listen or read when the patients cannot be seen and are in other hands. We learn by experience and that means actual contact with the sick. Treatment in the patient's home is of double value to the doctor for then he is likelier to understand the personal problems that may aggravate the illness. But there are some lessons that cannot be learnt in the home or office. For them the doctor must go to the hospital and unless this part of his education is attended to, the goal he strives for will not be reached.

Inasmuch as most patients in hospital are under the care of practitioners, and considering how desirable it is that the standard of hospital care should be high, it is obvious that hospitals can (and should) serve their practitioners in a very special way—not only can they house their doctors' patients, they can actively assist these

doctors to become more efficient.

Teaching hospitals can be particularly valuable. Most of the patients on staff wards have come from family doctors. Quite often, if not usually, the original doctor is informed of what was found and what was done during the patient's stay in hospital. But during the time there is seldom much contact between the two attendants. Certainly there is never the feeling that the equal interest of both men should lead to attendance by both. Only one, of course, can be responsible for the leaving of orders, but the reason for these orders and the results of their application should be recognized as a legitimate interest of the practitioner.

In theory at least we are concerned only with the welfare of the patient. What is best for him is the rule that guides us. Now, it seems obvious that the more the practitioner studies his patient in hospital, the oftener he discusses the case with the staff doctor, the better it is for the patient. For then, if sometime later that man takes ill in the night, his attendant is better prepared to give him help. Moreover, the close study of patients in a scientific way is instructive to the practitioner just as the practitioner's story of the **person** who is ill is instructive to the staff doctor.

And yet again, one of the principal demands we make is that nothing should be done to interfere with physician-patient relationship. That relationship is broken every time another doctor enters the picture. If the practitioner remains away from the patient during the time he is "on staff" it may be regarded as a sign of disinterest. Taking it by and large patients prefer the man they know to the one they don't know by very reason of that fact. It takes a little time—much time perhaps—to gain the same degree of confidence in a stranger. Furthermore, the woman whose doctor has known her for years as Mary Smith almost of necessity becomes "a heart" or "a lung" or "a kidney" to the staff doctor who has no particular reason for remembering her name.

Collaboration between practitioner and specialist would therefore serve a number of useful purposes. It would preserve the "doctor-patient relationship"; the specialist's greater knowledge of the process would be complemented and supplemented by the practitioner's greater knowledge of the person; the practitioner's studies would be illustrated and underlined in the most profitable way and from such instruction he would extend the frontiers of his competence.

Nor does this apply merely to medical cases. Surgical patients, also, should be under combined

care. How else is a man to improve himself in the things he can already do and advance to competent performance of things he has not yet done? Experience with one's own patients is better than listening to experiences of others. A very competent anaesthetist told me that one reason why practitioner-surgeons get such good results is "because they know their patients so well."

In hospitals not recognized as teaching institutions the same general rules apply. There are many experienced and highly competent men who would gladly play the role of preceptor. And, I venture to say, there are few practitioners who are so dishonest as to refuse to admit their limitations. The situation is indeed quite the contrary. Most doctors are conscious of their scope, but most of them, also, want to increase that scope. They wish to deepen as well as widen their knowledge, and hospitals can help them greatly. But they cannot do it if a hospital acts as a deterrent which it does when it says to any one: Thus far shalt thou go and no farther.

The matter, obviously, is a complex one. Licence is evidence of legal recognition. Hospital standards demand something more than the law requires. Practitioners must have the use of hospital facilities for their own improvement. The closed hospital denies them the opportunity to use these facilities. "Open" hospitals are few and small. How then are the practitioners going to increase their knowledge, technical skill and therefore their usefulness?

This is a matter that should absorb the attention of the General Practitioners Association. It is all very well to have an Academy but that will merely be the substitution of one name for another unless the Academicians are such by virtue of their elevated personal standard of care. This desirable improvement can be accomplished more fully and more satisfactorily at home, day by day, than abroad in attending conventions.

The open door to improved medical care is that of the hospital which is open to the practitioner as well as to his patients and which realizes that by helping the practitioner it also helps itself.

### Letter to the Editor

November 7, 1953.

The Editor,  
Manitoba Medical Review,  
Medical Arts Bldg.,  
Winnipeg, Manitoba.

Dear Sir:

Re: Elections Canadian Medical Association and Provincial Branches.

I spent a good deal of time in England during the deliberations that preceded the adoption of the National Health scheme in Great Britain.

One of the things that impressed me very much was the frequent charge, made by both

government officials and by those in favour of the National Health scheme, that the executive of the British Medical Association did not truly represent the Doctors of Great Britain. To support this statement figures were produced, which indicated that only a small segment of the total number of Doctors voted at any particular election during the annual conventions and therefore, the executive represented a small minority of the total number of Doctors.

This charge was unfortunate for two reasons. Firstly, it was impossible to refute because in favour the executive was elected by only a small proportion of the Doctors of Great Britain. Secondly, among people in government circles who are used to elections and are very alert to the proportion of individuals who vote for a particular party, this charge seemed to have considerable weight.

In view of the likelihood in the future of similar deliberations between our Canadian Medical Association executive and government officials, which may perhaps lead to some form of state medicine, I believe it would be wise to examine very seriously this particular aspect of our electoral methods. It seems to me possible that a mailed ballot to every member of the association (for the purpose of voting on a nominated list for the executive) could be put into effect without too much difficulty.

I would suggest that the current executive at this point a committee to study this aspect of the problem and introduce a report as to its desirability.

I believe that anything which would strengthen the power of the executive of our association in negotiation with the government would be to the benefit of the association and to the public at large.

Yours very truly,

Alan A. Klass, M.D.

### Special Contributions III Hospitals

The practice of medicine today depends more and more on hospitals. This is because of the very complex procedures necessary to give adequate care. It is generally recognized by the profession that adequate hospital care should be made available to all, regardless of race, color, creeds, social status, financial status or residence. In Manitoba, as elsewhere, every attempt is being made to bring to the people the very broad preventive, diagnostic and therapeutic care that can be given. The demands that have been made on the hospitals of the province during the last decade have been very great. To meet these demands many new hospitals have been built and many hospitals have added wings to the existing buildings. This has been made possible by the united efforts of hospital boards, the medical profession, governmental agencies and the generous

of the citizens of the province.

#### "New Medical Centre"

A group of buildings near the Winnipeg General Hospital will soon be added at a cost of \$8,000,000.00 and these, with the present buildings, will become a large medical centre. The overcrowding at the Winnipeg General Hospital was partly relieved by the building of the Maternity Pavilion at a cost of \$1,550,000.00. The Children's Hospital has old and obsolete buildings and the staff are working under extreme difficulties. The building will be abandoned and a new Children's Hospital will be built to become part of the new medical centre.

#### Additions to Existing Hospitals

New wings have already been added to the Grace Hospital, Victoria Hospital and the Veterans' Hospital at Deer Lodge. An enormous new wing is nearing completion at the St. Boniface Hospital. Plans are underway for a \$2,500,000.00 addition to the Misericordia Hospital.

#### Shriners Hospital

A few years ago a new hospital for crippled children was built on Wellington Crescent by the Shriners.

#### St. Joseph's Hospital

After serving the people of this province and especially north Winnipeg for many decades the St. Joseph's Hospital has had to close its doors. This has been a matter of concern to the medical profession but we were unable to do anything about it.

#### Princess Elizabeth Hospital

This beautiful building was built by the city to take care of the chronically ill and has made their rehabilitation possible in many cases.

#### King George Hospital

This year belongs to the King George Hospital, an institution that has handled in a magnificent manner the worst poliomyelitis epidemic of all time. At one time there were nearly one hundred patients in respirators requiring constant skilled medical care. The people of the province will never be able to repay the nurses and doctors for their tireless efforts on behalf of the bulbar poliomyelitis cases. Consider one hundred iron lung monstrosities, noisy and tireless, puffing and groaning away by night and day with nurses working through arm portholes until in some cases their arms were black and blue from pressure. The problems of feeding, intravenous therapy, bedsores, enemas, tracheotomies, maloid balances, confinements, were all handled in an efficient manner. The amount of work imposed on the staff was terrific and had to be seen to be appreciated. The dedication to duty of our doctors and nurses in that institution during the past few months merits our deepest gratitude. The cost of all this was very great and the Minister of Health deserves a great deal of credit for the way in which

he carried out the recommendations of the poliomyelitis advisory committee. The minister should have no fear when he brings his budget down in the legislature in a few months' time.

#### Nursing Units

Many of these have been built throughout the province and doctors in the rural areas are thus able to give much better service to their patients.

#### Hospital Committee

The executive of the Manitoba Medical Association, realizing the increasing complexity of hospital management, is setting up a small committee to work with hospital boards in order to have the present satisfactory hospital-doctor relationship. In most cases people in the province are not only able to choose their own doctor but they can also choose the hospital that they wish to enter, a situation which must make for greater contentment of both doctor and patient.

L. A. Sigurdson, M.D.

#### Obituary

##### Frank Chown, M.D., D.P.H.

With the passing of Frank Chown on 6th November, 1953, his colleagues in the Department of Health have suffered a grievous loss.

Born in Winnipeg, he moved with his family to Saskatoon at an early age. After some years as a teacher in the schools of that city, he proceeded to study medicine at Toronto. On graduation in 1942 he enlisted in the R.C.A.M.C. and was posted to A 22 at Camp Borden. There he assisted Lt.-Col. Morley Elliott in the establishment of the school in Military Hygiene. After qualifying in the D.P.H. course at the School of Hygiene, Toronto, he went overseas in 1944 as Commanding Officer of No. 10 Canadian Field Hygiene Section and remained in that capacity until the close of the war.

In 1946 he entered the Manitoba Department of Health as Medical Director of the Northern and later of the Selkirk Full Time Health Units. In 1950 he was engaged on the survey of Health Services and on 16th August, 1951, he was appointed Medical Director of the St. Boniface Health Unit.

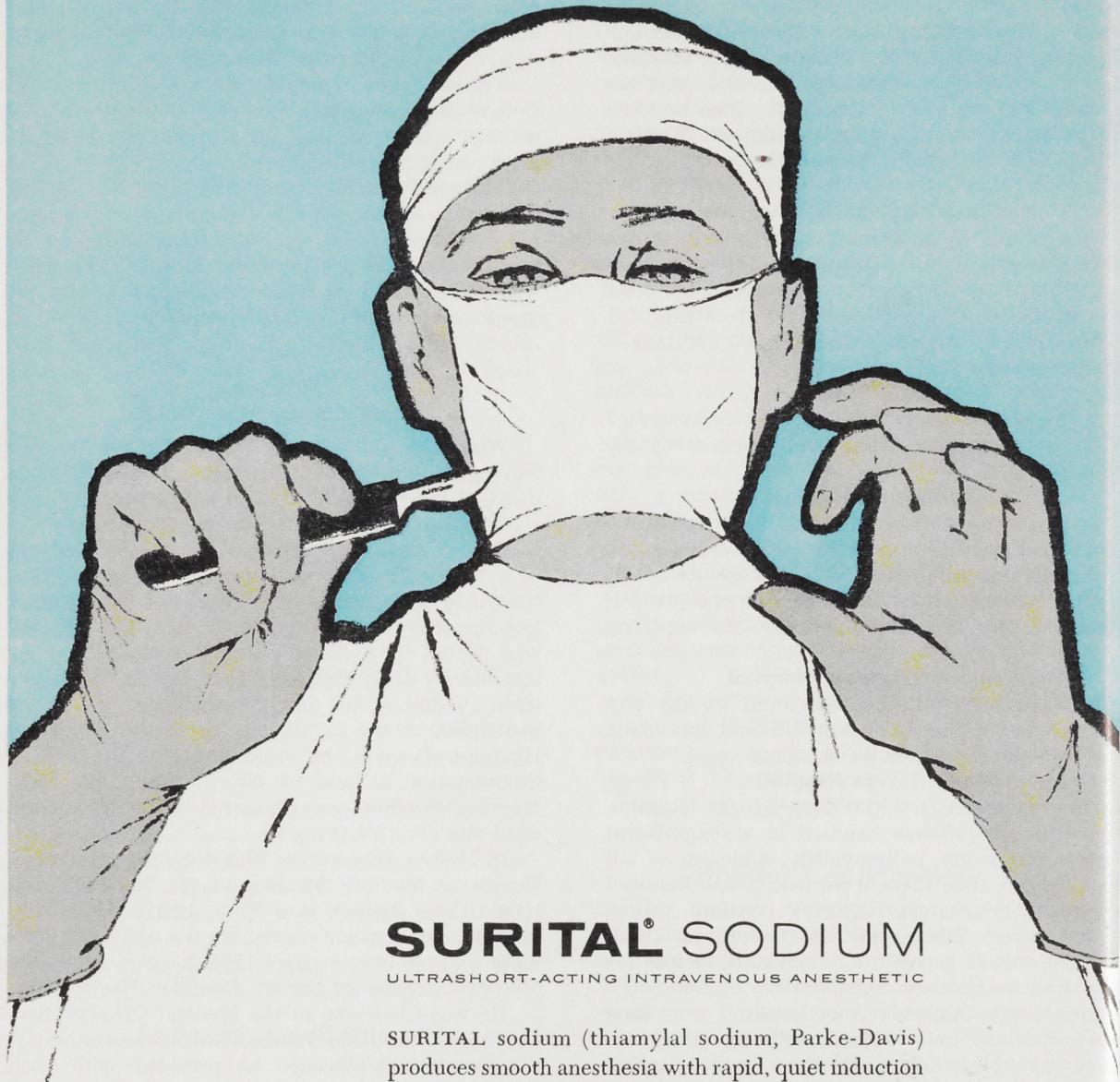
He was Chairman of the Medical Officers' Section of the Manitoba Public Health Association; at the October Conference he presided with such ability, cheerfulness and ready wit, that it was hard to recall he had passed through serious illness during the past several months, and none dreamed that the sword was to fall so soon.

His bright smile, his sturdy attitude, his eager endeavour, will remain in our memory a constant inspiration to greater heights of service.

It is a great privilege to have known him.

He was an ideal family man. To his wife who supported him so ably in all his work, and to his two sons and daughter we extend our heart felt sympathy.

Noel Rawson.



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## Association Page

Reported by M. T. Macfarland, M.D.

### Admission of Patients to Hospital for Dental Care

The following letter was submitted by the Association for expert opinion: "Further to our telephone communication concerning the admission of patients to hospital for dental care, the Manitoba Hospital Service Association requires the signature of a medical doctor in the form enclosed prior to admission of the patient to hospital by dentists.

"Your opinion as to the legal responsibility of a medical doctor who signs such a certificate is requested.

"A further opinion is requested in the case of the doctor who signs the certificate and is listed in the hospital records as the admission doctor, when the subsequent procedures are carried out by a member of the dental profession."

A reply was received dated May 27th, as follows:

"This will acknowledge receipt of your letter of the 26th instant in connection with the admission of patients to a hospital for dental care.

"The regulations of the Manitoba Hospital Service Association provide that hospital service shall be rendered only upon the recommendation of a duly qualified physician or surgeon, and may continue within the prescribed periods during which a subscriber may be under the treatment or care of such physician or surgeon in the hospital.

"The problem which presents itself insofar as dental care is concerned arises out of the foregoing reference to the Manitoba Hospital Service Association and the necessity for the attendance of a physician or surgeon.

"I have also examined the form of medical certificates which you left with me, and I cannot see anything particularly wrong therewith. It simply certifies as to the need for hospital care for conditions arising out of the need for dental care. This may satisfy the Manitoba Hospital Service Association, but I am inclined to the view that the relationship of doctor and patient is not created thereby. If such is the case, no responsibility would attach to the physician concerned by signing such certificate.

"I would suggest that further conferences with the Manitoba Hospital Service Association should be held before a final decision is reached."

The following is a letter received from C.M.P.A. under date of May 27th:

"With regard to the first point in your letter, Dr. Fisher feels that as the doctor is simply signing a statement of fact as to the patient's need

for admission and as long as this is a true statement, made in accordance with the doctor's own knowledge of the patient's condition and not on hearsay evidence, he need have no fear of the consequences.

"As far as the second point is concerned, if the dentist is a fully licensed dental practitioner and as long as the doctor agrees that the treatment is required, having seen the patient himself, he should have to assume no more responsibility than if he had called in a consultant in Urology or any other specialty, to carry out a special procedure on his patient."

### Northern District Medical Society

A meeting of the Northern District Medical Society was held in the General Hospital and Health Unit on Thursday evening, November 5th.

Following a delicious dinner which was served, guests were received by Mr. Smeidl, Administrator of the hospital, and dinner was served in the dining room under the direction of the dietitian.

At the Business Session which was held in the auditorium of the Health Unit and presided over by Dr. B. E. Symchych, the minutes of the previous meeting were read, aloud, by Dr. M. Potoski, and discussion followed concerning Manitoba Medical Service and fees paid by the Indian Health Services Branch of the Department of National Health and Welfare.

The scientific programme consisted of a discussion of "Some Complications in the Treatment of Poliomyelitis," by Dr. J. A. Hildes, Winnipeg. The address was copiously illustrated by kodachrome and black and white slides. A good discussion followed the presentation.

Dr. C. W. Wiebe, retiring President of the Manitoba Medical Association, reviewed highlights of the year's activities and thanked members for their co-operation. Dr. M. T. Macfarland referred to the minimum schedule of fees and demonstrated the schedule produced by the Northwest District Medical Society about 1922.

### Election of Officers

President: Dr. T. F. Malcolm, Swan River

Secretary: Dr. M. Potoski, Dauphin

Representative to M.M.A. Executive:

Dr. M. Potoski, Dauphin

### Brandon and District Medical Association

A meeting of the Brandon and District Medical Association was held at the Flying Club, Brandon, at 6.30 p.m., on Wednesday, November 4th.

Following a delicious chicken dinner to which about 65 persons sat down, the Business Session

was called to order by the President, Dr. J. B. Baker.

The minutes of the last meeting in March were read by the Secretary-Treasurer, Dr. R. F. M. Myers. No further developments were reported in the setting up of the Medico-Legal Society or branch of the Canadian Arthritis and Rheumatism Society. The setting up of a sub-depot for the Red Cross Blood Transfusion Service awaits the services of a full-time pathologist.

New business included preliminary discussion of the establishment of Cancer Diagnostic Clinics under the Cancer Relief and Research Institute and the proposed minimum schedule of fees for the Manitoba Medical Association.

Dr. C. W. Wiebe, President of the Manitoba Medical Association, reviewed highlights of the year's work and thanked the members for their interest and co-operation.

#### **Election of Officers**

The following officers were elected for the year 1953-54:

President: Dr. W. J. Sharman, Clanwilliam  
Vice-President: Dr. F. J. E. Purdie, Brandon  
Secretary-Treas.: Dr. V. J. H. Sharpe, Brandon  
Executive Committee.

Dr. A. H. Povah, Brandon

Dr. J. S. Brown, Brandon

Dr. G. T. McNeill, Carberry

Representative to M.M.A. Executive:

Dr. J. A. Findlay, Brandon

The scientific programme consisted of a talk by Dr. J. S. Brown, Brandon, on the subject of "Dysphagia," illustrated by X-ray films, and a discussion by Dr. J. A. Hildes, Winnipeg, of "Some Complications in the Treatment of Poliomyelitis," illustrated by kodachrome and black and white slides.

Following the scientific session members and their ladies enjoyed a social hour.

#### **The Southern District Medical Society**

A meeting of the Southern District Medical Society was held in the Lecture Room of the Carman General Hospital at 3 o'clock on Thursday, November 19th.

Present were: Dr. W. M. Colert, Morden, President; Dr. J. C. Menzies, Morden, Sec.-Treas; Dr. A. F. Menzies, Morden; Dr. J. C. Elias, Morris; Dr. J. H. Boucher, St. Jean; Dr. E. K. Cunningham, Carman; Dr. W. H. C. North, Carman; Dr. P. H. Friesen, Emerson; Dr. T. D. Miller, Oakville; Dr. W. Krywulak, Roland; Dr. A. P. Warkentin, Winkler; Dr. C. W. Wiebe, Winkler; Dr. A. Hollenberg, Winnipeg; Dr. R. O. Burrell, Winnipeg; Dr. F. L. Jamieson, Winnipeg; Dr. D. J. Fraser, Winnipeg; Dr. E. H. Whelpley, Winnipeg; Dr. M. T. Macfarland, Winnipeg; Dr. W. F. Tisdale, Winnipeg; Dr. J. McKenty, Winnipeg.

#### **Business Session**

The minutes of the last meeting were read by the Secretary-Treasurer and approved by the meeting.

Dr. J. C. Elias, Morris, was named Representative to the Executive Committee of the General Practitioners Association of Manitoba and Dr. J. R. McDougall was named Representative to the Executive Committee of the Manitoba Medical Association for the year 1953-1954.

#### **Election of Officers**

President: Dr. J. C. Elias, Morris

Secretary-Treasurer: Dr. H. Boucher, St. Jean

A welcome was extended to Dr. W. F. Tisdale, President of the Manitoba Medical Association who spoke briefly concerning the work of the Association, the new fee schedule and the Manitoba Medical Service. Dr. Jack McKenty, Chairman of the Canadian Medical Association Section of General Practice, spoke concerning the establishment of the "College of General Practice." Dr. E. H. Whelpley, Department of Veterans' Affairs, and Dr. D. J. Fraser, Workmen's Compensation Board, and Dr. F. L. Jamieson, spoke briefly and a discussion concerning Manitoba Medical Service was encouraged by Dr. A. Hollenberg.

#### **Scientific Programme**

Dr. A. Hollenberg, of Winnipeg, spoke on the newer aspects of Diabetes Mellitus and Dr. R. O. Burrell spoke on Thrombo-embolic Phenomena. Each paper was followed by a lively discussion.

#### **Social**

Following a visit of the hospital, members sat down to an appetizing meal prepared and served by the staff of the hospital. A vote of thanks was proposed by Dr. M. T. Macfarland who also spoke briefly of the contribution of the Southern District Society to the work of the Association during the past year, and lead a brief discussion on the question of the new fee schedule.

## **Winnipeg Medical Society**

Reported by R. H. McFarlane

The regular meeting of the Winnipeg Medical Society was held on the 29th of November, at the Medical College.

The first major item of business was a motion by Dr. Allison regarding the reports of the various committees and sections of the Society which are usually read at the annual meeting. Dr. Allison's motion was carried with no opposition at all and this year, therefore, committee reports and section reports will be published and circulated to the members of the Society in advance of the annual meeting and will not be read at the meeting itself. Opportunity will be provided, however, for discussion of any of the reports at that meeting. This will certainly have the effect of shortening the

annual business meeting and should allow it to be a more enjoyable occasion.

Dr. Harry Medovy spoke briefly about the survey of heart disease in school children and stated that a questionnaire would shortly be sent out to physicians who had noted murmurs or cardiac lesions on the examination forms of school children. On reviewing these forms, there were found 239 instances of systolic murmurs with no other cardiac pathology noted, and it was felt that if fuller information were available, only a small number of these would actually be barred from any of the school activities and athletics.

The main speaker of the evening, Dr. Colin C. Ferguson, has recently been appointed Professor of Surgery at the University of Manitoba. He was introduced by his predecessor in this office, Dr. C. W. Burns. Since Dr. Ferguson is a graduate of the University of Manitoba, Dr. Burns was able to mention some of his trials and tribulations as

an interne and student as well as the highlights of his career in surgery thus far. Dr. Ferguson spoke about the surgery of congenital heart disease and limited his remarks to those conditions in which surgery is now a relatively well-established therapeutic procedure. In particular, he spoke about the history of surgery for patent ductus arteriosus, coarctation of the aorta, constriction of the trachea and esophagus by anomalous great vessels, tetralogy of Fallot, and pulmonic stenosis. A major portion of his time was allotted to showing a coloured movie of an operation for coarctation of the aorta. This was a very interesting summary of current knowledge of surgery for these conditions and I understand the paper will be published elsewhere in the Review. His paper was very well received and the interest it generated was illustrated by the fact that no less than fourteen members of the Society contributed to the discussion afterwards.

R. H. McFarlane, M.D.

## General Practitioners

General Practitioners' Association of Manitoba  
In Affiliation with the Manitoba Medical Association

### The College of General Practice of Canada

The movement for self-improvement amongst the General Practitioners of Canada which began to gather momentum some five years ago is now about to be stripped of its trappings and stand before the profession in the form of a College of General Practice of Canada. This College will be a rallying point for all those engaged in the general practice of medicine who feel that through their own effort the standard of general practice can be raised and recognized.

During this five-year period groups of earnest general practitioners have been meeting, sometimes in formal sessions, but more often in the halls and bedrooms of hotels across Canada, studying and clarifying the remedy for the loss of public and professional prestige which has paralleled the rise of specialization in Canadian medicine.

At the meeting of the Canadian Medical Association in Banff a group of six men was appointed to inquire into all aspects of this movement and to make recommendations to the next council meeting of the C.M.A. This committee took its work seriously and reported to the Winnipeg meeting this year that a College of General Practitioners should be established, independent of the C.M.A. and the Royal College of Physicians and Surgeons of Canada. To accomplish this an organizing committee of seven was nominated by the Section on General Practice of the C.M.A. and approved by the Executive Committee with power to do

all things necessary to establish the College.

The organizing committee met in Toronto on October 16th and 17th and attempted to put down on paper some rules and regulations that would govern the College until such time as a formal constitution could be approved by a meeting of the members of the College.

A question frequently asked by both general practitioners and specialists alike is, "What are the aims and objects of this College?" The answer to this is contained in the listed aims and objects as presented to the C.M.A. Council:

- (1) To establish an academic body with broad educational aims.
- (2) To arrange for undergraduate teaching by and for General Practitioners.
- (3) To arrange for the presentation of Post Graduate education for General Practitioners.
- (4) To arrange for Research in General Practice.
- (5) To arrange for publication of original articles by General Practitioners.
- (6) To arrange for Hospital Staff Appointments for General Practitioners.
- (7) To provide suitable recognition to members in the field of General Practice.
- (8) To do all things necessary to maintain a high standard in General Practice.

These aims and objects would indicate that the prime function of the College is to be educational. The medical-economic and political aspects of medical practice will remain with medical associations. As membership in the Canadian Medical Association or L'Association des Medecins de

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\* Manson, M. H.; Wells, R. L.; Whitney, L. H.; and Babcock, G., Jr.: Internat. Arch. Allergy & Applied Immunol 1: 265, 1951.



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Langue Francaise de Canada is one of the conditions of membership in the College, it should not be difficult to delineate the functions of each.

The necessity for the College is to provide a stimulus to general practitioners to continue a post graduate educational programme throughout their years of practice. This stimulus will be membership and/or fellowship in the College—standards of excellence that will come to take their place with certification and fellowship in the specialty colleges.

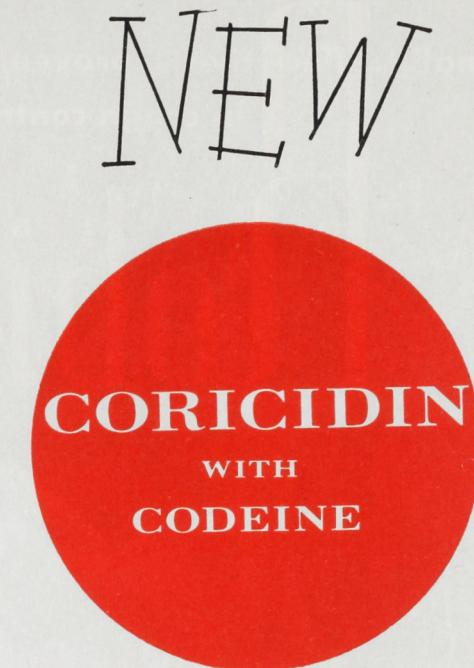
At the present time many young graduates feel that they should have a certificate of some kind even if they are desirous of entering general practice. They spend a few years in acquiring the required specialized knowledge only to find themselves poorly equipped to meet the multiplicity of problems presenting themselves in a general practice. It will be the object of the College to establish educational facilities that will meet the needs of the General Practitioners. This may require some changes in the undergraduate teaching programme and will definitely necessitate the establishment of two- and three-year internships in the hospitals of Canada of such design that they will give the interns a well-rounded basic knowledge of modern medicine in all departments of practice.

It has been the feeling of many practitioners that the "once and forever" granting of a certificate or Fellowship does not meet the needs of the general practitioner. Retention of Membership or Fellowship in the College will require the general practitioner to take a prescribed number of hours of post graduate study each two years. Part of this will be attendance at formal clinical sessions and part will be participation in local medical activities such as hospital rounds, branch medical meetings, writing and reviewing papers and reading courses.

One of the deterrents to the establishment of a College of General Practice has been finances. It is realized that only a small percentage of the General Practitioners will come forward with early support of the College. Many will adopt a wait-and-see attitude. With this thought in mind a Foundation Fund is to be established early in 1954 with the hope that many interested parties and individuals will rally to the support of this forward step in medical education.

The next issue of the Review should contain details of membership classification and requirements; the concept of a continuing educational programme; the names of the Executive Committee, the Board of Representatives and the Executive Director; the date of acceptance of membership applications and the official launching of the College.

—Furnished by Dr. J. McKenty, President, Section of General Practice, C.M.A.



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\*Brand of chlorprophenpyridamine maleate.



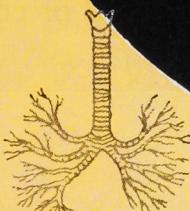
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\*Cass, L. J. and Frederik, W. S.: Amer. Pract. and Dig. of Treat., 2:844, 1951. (In this study Robitussin was compared with ammonium chloride and terpin hydrate.)

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## College of Physicians and Surgeons of Manitoba

### Registration Committee

May 27, 1953

#### Resolution of Council Re University of Manitoba

#### Assessing Documents of Applicants for Enabling Certificates and/or Registration

After considerable discussion of the motion passed at the Council Meeting on May 23rd, it was agreed that the Chairman and President draft a letter to the Vice-Chancellor of the University of Manitoba, enclosing the resolution and outlining the policy of the College concerning applicants for Enabling Certificates and/or registration, for presentation to the Senate of the University which meets on June 4th, 1953.

#### Enabling Certificates Deferred

Gerhard Conradi, M.D., Friedrich-Schiller U., 1942.

Peter Henry Mierau, M.D., U. Odessa, 1939.

Gerd Asche, M.D., Friedrich-Wilhelm U., Bonn, 1951.

Edward Shih-chung Chan, M.D., National Medical College of Shanghai, 1949.

#### Certificate of Registration Confirmed

Gordon Howard Valentine, M.B., Ch.B., U. Bristol, 1942; M.R.C.S., Eng., 1942; L.R.C.P., Lond., 1942; M.R.C.P., Lond., 1947; D.C.H., R.C.P.S., Eng., 1950.

#### Certificates of Licence (Temporary) Granted

Robert Alistair Laing, M.B., Ch.B., U. Aberdeen, 1950.

Stephen Joseph O'Rourke, L., L.M., 1949, R.C.P., Irel., L., L.M., 1949, R.C.S. Irel.

### Specialist Committee

June 22, 1953

The third meeting of the College of Physicians and Surgeons Committee to set up a Specialist Register was held at 1.00 p.m., in the Medical Arts Club Rooms, on Monday, June 22nd, 1953.

Present: Dr. C. H. A. Walton, Chairman, C.P. & S.; Dr. M. R. MacCharles, M.M.A.; Dr. F. G. Allison, M.M.A.; Dr. B. D. Best, Faculty of Medicine, U. of Manitoba; Dr. N. L. Elvin, Faculty of Medicine, U. of Manitoba, and Dr. M. T. Macfarland, Registrar, C.P. & S., ex-officio.

The Chairman read the names of 18 members, with Royal College standing, whose names had been entered on the Specialist Register since the last meeting of the Committee, as well as 5 members whose applications had been approved at the last meeting of the Committee.

Of the 20 applications considered at this meeting, 13 were granted Specialist Registration, 5 were deferred pending receipt of additional information, and 2 were refused because their qualifications were inadequate under the By-law of the College of Physicians and Surgeons of Manitoba.

### Registration Committee

June 29, 1953

#### Enabling Certificates Deferred

Edward Shih-chung Chan, M.D., National Medical College of Shanghai, 1949.

Karl Hugo Erich Kruger, M.D., Danzig U., 1941. James Y. J. Ch'uai, M.B., Ch.B., Mukden Medical College, 1930.

#### Enabling Certificates Granted

Stefan Friedrich, M.D., U. Vienna, 1939.

Ruben Hilton Mayberry, M.D., U. Louisville, Kentucky, 1950.

#### Certificates of Registration Confirmed

Arthur Stuart Majury, M.B., B.Ch., Queen's U., Belfast, 1941; M.R.C.O.G., 1950.

John Houston McBeath, M.B., Ch.B., U. Glasgow, 1940; F.R.C.S., Edinburgh, 1948.

#### Certificates of Registration Granted

Richard Harold Dougherty Sykes, M.R.C.S., England, 1951; L.R.C.P., London, 1951.

Max Herve Leopold Desmarais, M.R.C.S., England, 1939; L.R.C.P., London, 1939; D.P.M., R.C.P.S., England, 1947.

#### Certificate of Registration Refused

Morris Kunsztler, M.D., U. Budapest, 1906.

#### Certificate of Licence (Temporary) Granted

Mieczyslaw Kozakiewicz, M.D., U. Warsaw, 1926; D.P.H., U. Toronto, 1953.

### Registration Committee

August 5, 1953

#### Enabling Certificates Deferred

Gustaaf Adolf Mertens, M.D., U. Leiden, 1950.

Gregor Bronstein, M.D., l'Aurore U., 1935; M.D., U. Aix Marseille, 1940.

James Y. J. Ch'uai, M.B., Ch.B., Mukden Medical College, 1930.

Wolfgang Schlichther, M.D., U. Innsbruck, 1948.

Maria Helman Zalewska, M.D., U. Wilno, 1930.

Rose Wen-chiu Hu, M.D., U. Michigan, 1949.

#### Enabling Certificates Granted

Lajos Kovacs, M.D., Royal Hungarian U. Pazmany Peter in Budapest, 1931.

Gerd Asche, M.D., Friedrich-Wilhelm U., Bonn, 1951.

#### Certificate of Registration Deferred

Theodor Tyzek, M.D., Lwow U., 1938; M.D., Leipzig U., 1943; L.M.C.C., 1953.

#### Certificates of Registration Confirmed

Sarah Margaret Elliott, M.D., C.M., Queen's U., 1947; L.M.C.C., 1947.

Lorant Ferenc Kocsis, M.D., Royal Hungarian Elizabeth U., 1944; L.M.C.C., 1953.

#### Certificates of Registration Granted

Douglas Woodrow Cardozo, M.D., St. Louis U., 1941; L.M.C.C., 1953.

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LIPOTROPE GERIATRIC:  
12 oz. ½ and 1 gallon.

• *Improved flavour*

In geriatrics

*Lipotrope  
geriatric*

a pleasantly palatable elixir

\* Particularly suitable for pediatric use

**ROUGIER FRÈRES, 350 LE MOYNE STREET, MONTREAL**

David Alexander Ian Grewar, M.B., Ch.B., U. St. Andrews, 1945; D.C.H., R.C.P.S., London, 1950; M.R.C.P., Edinburgh, 1953.

Wolodymyr Czubaty, M.D., U. Carl, Prague, 1929; L.M.C.C., 1953.

#### Certificates of Licence (Temporary) Confirmed

Ernest Keith Fitzgerald, M.D., U. Toronto, 1950; L.M.C.C., 1950.

Wolodymyr Krywulak, M.D., Lwow U., 1944; L.M.C.C., 1953.

James Alexander Miller, M.D., U. Western Ontario, 1946; L.M.C.C., 1946.

#### Certificate of Licence (Temporary) Granted

William Gordon Lamberd, M.B., Ch.B., U. Liverpool, 1952.

### Registration Committee

September 9, 1953

#### Enabling Certificate Deferred

Edward Shih-chung Chan, M.D., National Medical College of Shanghai, 1949.

#### Enabling Certificates Granted (if certain conditions fulfilled)

Rose Wen-chiu Hu, M.D., U. Michigan, 1949.

James Y. J. Ch'uai, M.B., Ch.B., Mukden Medical College, 1930.

I-Hsuan Chang, M.D., Cheeloo U., 1926.

Guerino C. Goyo, M.D., Turin U., 1948.

Chiu-chen Wang, M.D., National Kwei-ying Medical College, 1948.

#### Enabling Certificates Granted

Gregor Bronstein, M.D., l'Aurore U., 1935; M.D., U. Aix Marseille, 1940.

Gustaaf Adolph Mertens, M.D., U. Leiden, 1950.

Wu Lou, M.D., l'Aurore U., 1941.

Gerhard Conradi, M.D., Friedrich-Schiller U., 1942.

#### Certificates of Registration Confirmed

Theodor Tyzek, M.D., Lwow U., 1938; M.D., Leipzig U., 1943; L.M.C.C., 1953.

Humphry Bohun Kidd, M.B., B.Ch., U. Cambridge, 1947.

Howard Newns Reed, M.R.C.S., England, 1941; L.R.C.P., London, 1941; D.O.M.S., R.C.P.S., England, 1946; D.O., Oxford U., 1947; F.R.C.S., England, 1950; M.B., B.S., U. London, 1951; M.S., Ophthalmology, U. London, 1952.

Clive Thomas Gonsalves, M.D., C.M., McGill U., 1948; L.M.C.C., 1949.

#### Certificate of Registration Granted

David Gerald Lloyd-Davies, M.R.C.S., England, 1940; L.R.C.P., London, 1940; D.L.O., R.C.P.S., England, 1947; F.R.C.S., Edinburgh, 1948.

#### Certificate of Licence (Temporary) Confirmed

Donald Eric Ryder, M.B., Ch.B., U. Edinburgh, 1949.

The case of \_\_\_\_\_ was considered at some length and a recommendation forwarded to the Executive Committee.

### Executive Committee

September 10th, 1953

A meeting of the Executive Committee was held in the Medical Arts Club Rooms at 1 pm., on Thursday, September 10th, 1953.

Present: Dr. C. B. Stewart, Chairman; Dr. C. H. A. Walton, Dr. Ed. Johnson, Dr. C. E. Corrigan, President, ex-officio, and Dr. M. T. Macfarland, Registrar.

#### 1. Business Arising From Council Meeting May 23, 1953

##### A. Election of Council

At the May meeting of Council, a motion was passed giving the Registrar authority to set up the machinery for an election of Council after the Annual Meeting in October, 1953, according to the amendment to the Medical Act, assented to on April 18, 1953. Normally the election would not be held until 1955, and a communication was presented from Mr. T. W. Laidlaw advising that it would be in order to proceed with the elections in the ordinary manner.

The Executive Committee agreed to leave the election of Council in abeyance until the Annual Meeting of Council. It was also pointed out that Council would have to decide which representatives would hold office for two years, and which for four years, before the election.

##### B. Amending By-laws

The Registrar advised that the Council empowered the Legislative Committee to review the By-laws to bring them into line with the amended Medical Act and report to Council, but that no meeting of the Committee had been held to date.

##### C. Registrars' Meeting

The Registrar advised that a luncheon meeting of the Registrars of the various Colleges across Canada had been held on June 18th, 1953, at the time of the Canadian Medical Association Convention, and presented mimeographed copies of minutes.

The Committee agreed that the minutes of the Registrars' Meeting should be forwarded to members of Council with the agenda.

##### D. Medical Registration Council, Dublin, Eire

An additional letter, received since the May Council meeting from the Registrar of the Dublin Medical Registration Council, was presented. The communication advised that the correspondence about reciprocity was considered by their Council which agreed to ask the Government to make an Order applying Section 26 of the principal Act to Manitoba, and requesting whether the Manitoba Council was prepared to make a formal arrangement about reciprocity for registration.

The Committee agreed to pass this communication to the Council meeting in October for a decision.

### E. Date of Council Meeting

The Council, at the May meeting, left the setting of the date of the October Council meeting to the discretion of the Executive Committee. It was pointed out that the Manitoba Medical Association meeting was being held on October 15th and 16th, and that other meetings were being held during the same week. The Registrar suggested postponement until mid-November.

**Motion:** "THAT the Annual Meeting of the Council be held at 10.00 a.m., on Saturday, Oct. 17th, 1953, in the Medical College." Carried.

### 2. Business Arising From Registration Committee Meeting, September 9th, 1953

Dr. Walton outlined the additional information received since the May Council meeting when it was advised that an Enabling Certificate had been issued to \_\_\_\_\_ and presented the following recommendation of the Registration Committee:

"THAT the Registration Committee recommend to the Executive Committee that the Enabling Certificate issued to \_\_\_\_\_ be cancelled, and that the matter be referred for information and any further action to the Medical Council of Canada."

Dr. Walton stated that there was no reference to the \_\_\_\_\_ problem on the agenda of the Medical Council of Canada Annual Meeting, and requested that a night-letter be forwarded to the Registrar and President of the Council explaining the events that led up to the cancellation of the Enabling Certificate, and requesting that the matter be placed on the agenda of the Medical Council of Canada meeting in Ottawa, Sept. 14th and 15th.

**Motion:** "THAT the resolution of the Registration Committee re \_\_\_\_\_ be approved by the Executive Committee, and the Registrar be instructed to send a night letter to the Registrar and President of the Medical Council of Canada to request urgently that the matter be placed on the agenda." Carried.

It was agreed not to notify \_\_\_\_\_ until the matter had been considered by the Medical Council of Canada.

### 3. New Business

#### A. Communication From Joint Hospital Building Fund

A copy of "Hub Notes" issued by the Joint Hospital Building Fund was presented outlining their appeal for funds, and the Registrar read his reply that the C.P. & S. does not contribute to public appeals of this nature, but the worthiness of the cause is one which has already appealed and will continue to appeal to the generosity of individual members.

#### B. Auditors

The Registrar advised that he had discussed in detail with Mr. Smith of Price Waterhouse & Co., the adjustments which might be made to simplify

accounting, and reduce amount of work involved in audit, and outlined the various suggestions made.

The Committee agreed to recommend to Council that the suggestions be accepted.

#### C. Purchase of Addressograph

The Registrar advised he had been looking into the advisability of purchasing an addressograph machine. He said it would be a three-way enterprise between the M.M.A., W.M.S. and C.P. & S. and would be a great time saver as far as sending accounts and addressing envelopes for the various sections. He explained that the present system entails sorting stencils for the various sections, running them off on the machine, then replacing them in the file, but with the addressograph there is a tabulating system which does away with this. He thought the price would be about Three Hundred Dollars (\$300.00), but there would be no trade-value on the old machine.

**Motion:** "THAT the Executive Committee favourably recommend to the Liaison Committee that an Addressograph be purchased for use in the combined office, the cost to be shared by the three organizations, Manitoba Medical Association, Winnipeg Medical Society, and the College of Physicians and Surgeons." Carried.

#### D. Discipline Committee

Dr. Johnson advised he had a file of a complaint against a doctor. He said he had letters from all concerned, and proposed to forward the file by registered mail to each member of the Discipline Committee requesting comments, and would bring in a report to the Council meeting.

Adjournment.

### Registration Committee

October 6, 1953

#### Enabling Certificate Deferred

Karl Hugo Erich Kruger, M.D., Danzig U., 1945

#### Enabling Certificate Confirmed

Roman Buczok, M.D., U. Madrid, 1951; Ph.D., U. Madrid, 1952.

#### Certificates of Registration Granted

Peter Thomas John Christopher Plumby Warner, M.R.C.S., England, 1944; L.R.C.P., London, 1944; M.B., B.S., U. London, 1945; M. (Pathology), U. London, 1948; Ph.D. (Pathology), U. London, 1951.

Charles George Gordon Mackay, M.B., Ch.B., Edinburgh, 1938; F.R.C.S., Edinburgh, 1947.

John Islwyn Davies, M.R.C.S., England, 1944; L.R.C.P., London, 1940; D.A., R.C.P.S., England, 1946; L.M.C.C., 1950; Cert. Anaesthetist, 1951.

R.C.P.S. (C), 1951.

#### Certificates of Registration Deferred

John Joynson Pepper, M.B., Ch.B., U. Edinburgh, 1943.

Glen Harrison Lowther, M.B., Ch.B., U. Glasgow, 1949.

**Department of Health and Public Welfare**  
**Comparisons Communicable Diseases — Manitoba (Whites and Indians)**

DISEASES	1953		1952		Total	
	Nov. 1 to Nov. 28, '53	Oct. 4 to Oct. 31, '53	Nov. 2 to Nov. 29, '52	Oct. 5 to Nov. 1, '52	Jan. 1 to Nov. 28, '53	Jan. 1 to Nov. 29, '52
Anterior Poliomyelitis	118	279	42	121	2301	802
Chickenpox	159	49	222	164	1198	1409
Diphtheria	0	0	0	0	4	2
Diarrhoea and Enteritis, under 1 yr.	13	26	11	13	169	157
Diphtheria Carriers	0	0	0	0	0	0
Dysentery—Amoebic	0	0	0	0	0	0
Dysentery—Bacillary	5	2	2	3	22	26
Erysipelas	0	1	5	0	26	18
Encephalitis	0	2	0	0	9	5
Influenza	11	12	6	13	229	158
Measles	148	46	468	162	2471	1858
Measles—German	4	1	1	0	44	14
Meningococcal Meningitis	3	3	0	2	30	16
Mumps	38	27	123	67	925	1316
Ophthalmia Neonatorum	0	0	0	0	0	1
Puerperal Fever	0	0	0	1	0	2
Scarlet Fever	69	21	53	35	396	622
Septic Sore Throat	5	8	3	2	92	76
Smallpox	0	0	0	0	0	0
Tetanus	0	0	0	1	2	4
Trachoma	0	0	0	0	0	0
Tuberculosis	80	61	1	60	775	849
Typhoid Fever	0	0	0	0	1	5
Typhoid Paratyphoid	0	0	0	0	0	2
Typhoid Carriers	0	0	0	0	0	0
Undulant Fever	1	0	0	0	10	5
Whooping Cough	18	23	14	14	165	416
Gonorrhoea	89	113	82	87	1152	1198
Syphilis	12	4	9	7	81	107
Infectious Jaundice	40	20	17	8	299	69
Tularemia	0	0	0	0	2	4

Four-Week Period November 1st to November 28th, 1953

**DISEASES**

(White Cases Only)

\*Approximate population.

	*798,000 Manitoba	*861,000 Saskatchewan	*3,825,000 Ontario	*2,952,000 Minnesota
Anterior Poliomyelitis	118	42	131	109
Chickenpox	159	406	1381	—
Diarrhoea & Enteritis under 1 yr.	13	34	—	—
Diphtheria	—	—	1	3
Diphtheria Carriers	—	—	—	—
Dysentery — Amoebic	—	—	—	3
Dysentery — Bacillary	5	1	21	11
Encephalitis Epidemica	—	1	—	2
Erysipelas	—	1	6	—
Influenza	11	—	13	6
Infectious Jaundice	40	34	109	92
Measles	148	65	341	12
German Measles	4	8	44	—
Meningitis Meningococcus	3	1	3	3
Mumps	38	176	684	—
Ophthal. Neonat.	—	—	—	—
Puerperal Fever	—	—	—	—
Scarlet Fever	69	35	335	72
Septic Sore Throat	5	3	8	35
Smallpox	—	—	—	—
Tetanus	—	—	—	—
Trachoma	—	1	—	—
Tuberculosis	80	59	91	177
Typhoid Fever	—	2	6	1
Typh. Para-Typhoid	—	—	2	—
Typhoid Carriers	—	—	—	—
Undulant Fever	—	1	—	6
Whooping Cough	18	76	168	12
Gonorrhoea	89	—	216	12
Syphilis	12	—	78	—

**DEATHS FROM REPORTABLE DISEASES**

For the Month of November, 1953

**Urban** — Cancer, 50; Influenza, 1; Pneumonia, Lobar, 2; Pneumonia (other forms), 10; Poliomyelitis, 1; Tuberculosis, 1; Diarrhoea and Enteritis, 4. Other deaths under 1 year, 25. Other deaths over 1 year, 206. Stillbirths, 13. Total, 244.

**Rural** — Cancer, 33; Influenza, 2; Pneumonia, Lobar, 3; Pneumonia (other forms), 10; Pneumonia of Newborn, 2; Poliomyelitis, 5; Tuberculosis, 4; Diarrhoea and Enteritis, 1. Other deaths under 1 year, 19. Other deaths over 1 year, 174. Stillbirths, 12. Total, 205.

**Indians** — Cancer, 2; Pneumonia (other forms), 1; Diarrhoea and Enteritis, 2. Other deaths under 1 year, 2. Other deaths over 1 year, 4. Total, 11.

♦

**Poliomyelitis** has been waning steadily during the past four weeks. As of December 11th, 2,321 cases have been reported and 85 of these have died. The only other communicable disease with a higher incidence reported is **Measles**.

**Diarrhoea and Enteritis** under 1 year continues to be a problem. Cleanliness is one of the chief factors required to control this disease; refrigeration of milk and other foods is another and, of course, proper housing is a third.

**Immunization** should be carried on again at full speed to make up for time lost during the polio epidemic. Let us at least control the diseases for which we have good preventives.

Clinical experience has clearly demonstrated the effectiveness of PLEXONAL in the treatment of anxiety neuroses and insomnia particularly in the presence of over-activity of the sympathetic nervous system.

Sedative dose:

1 or 2 tabs. 2 or 3 times daily.

Hypnotic dose:

1 to 3 tabs. at bedtime.

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